

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2186

CERTIFICATE OF DEATH

02157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradenbury Park</i>			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>Deo. A. Prince George San Hosp</i>		e. STREET ADDRESS <i>2201 Gaylord Drive</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>VIRGINIA</i>		First <i>ELLA</i>	Middle <i>ADAIR</i>	4. DATE OF DEATH <i>February 3, 1959</i>	Month <i>February</i>	Day <i>3</i>	Year <i>1959</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 3, 1906</i>	
9. AGE (In years last birthday) <i>52 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>5</i> Days <i>2</i> Hours <i>0</i> Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Chaperone Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William J. Curtis</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Payne</i>				Address <i>2201 Gaylord Dr., Bradbury Park, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. Doris A. Watson</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>190X</i> DUE TO Carcinoma of right breast	
						INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>November 1957</i> , to <i>February 3, 1959</i> , that I last saw the deceased alive on <i>February 2, 1959</i> , and that death occurred at <i>5:45 AM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>800 New Hampshire Ave. N.W. Feb 3, 1959</i>	
ACTUAL SIGNATURE <i>Forest R. Harris II</i>		M.D.				DATE SIGNED <i>March 7, 1959</i>	
PHYSICIAN'S NAME (Type) <i>FOREST R. HARRIS II</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 6, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i>		ADDRESS <i>800 Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>FEB 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Tracy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

232

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
John W. H.	60	M	Cardiac Arrest
ADDRESS	PHONE NUMBER	TIME OF DEATH	PLACE OF DEATH
123 Main Street	555-1234	10:00 AM	Hospital
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF FUNERAL DIRECTOR		
Dr. John Doe, MD, 123 Main Street	Funeral Home, 123 Main Street		
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
Signature: John W. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG239 3-13-59 et

CERTIFICATE OF DEATH

#2158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md	c. LENGTH OF STAY IN 1b 6 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6314 Tuckerman Street		d. STREET ADDRESS 6314 Tuckerman Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura May Adams	First	Middle	Last
4. DATE OF DEATH Dec 2, 1871	Month February	Day 28, 19	Year 59-
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 2, 1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 87	11. IF UNDER 24 HRS. Days 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Stewart Mc Coy		14. MOTHER'S MAIDEN NAME Mahala Caburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Beulah Bartholomew	Address Riverdale Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis (multiplied)			
DUE TO 332X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Cerebral Thrombosis (multiplied)			
DUE TO Generalized arterio-sclerosis			
(c) Generalized arterio-sclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
DUE TO Bronchial Asthma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Set 1959 to Dec 2, 1959 , that I last saw the deceased alive on Set 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4713 Bealeton Rd	
ACTUAL SIGNATURE W.C. ETIENNE		DATE SIGNED 3/4/59	
PHYSICIAN'S NAME (Type) W.C. ETIENNE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF March 1, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln	22d. LOCATION (City, town, or county) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR DATE MAR 4 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2244

CERTIFICATE OF DEATH

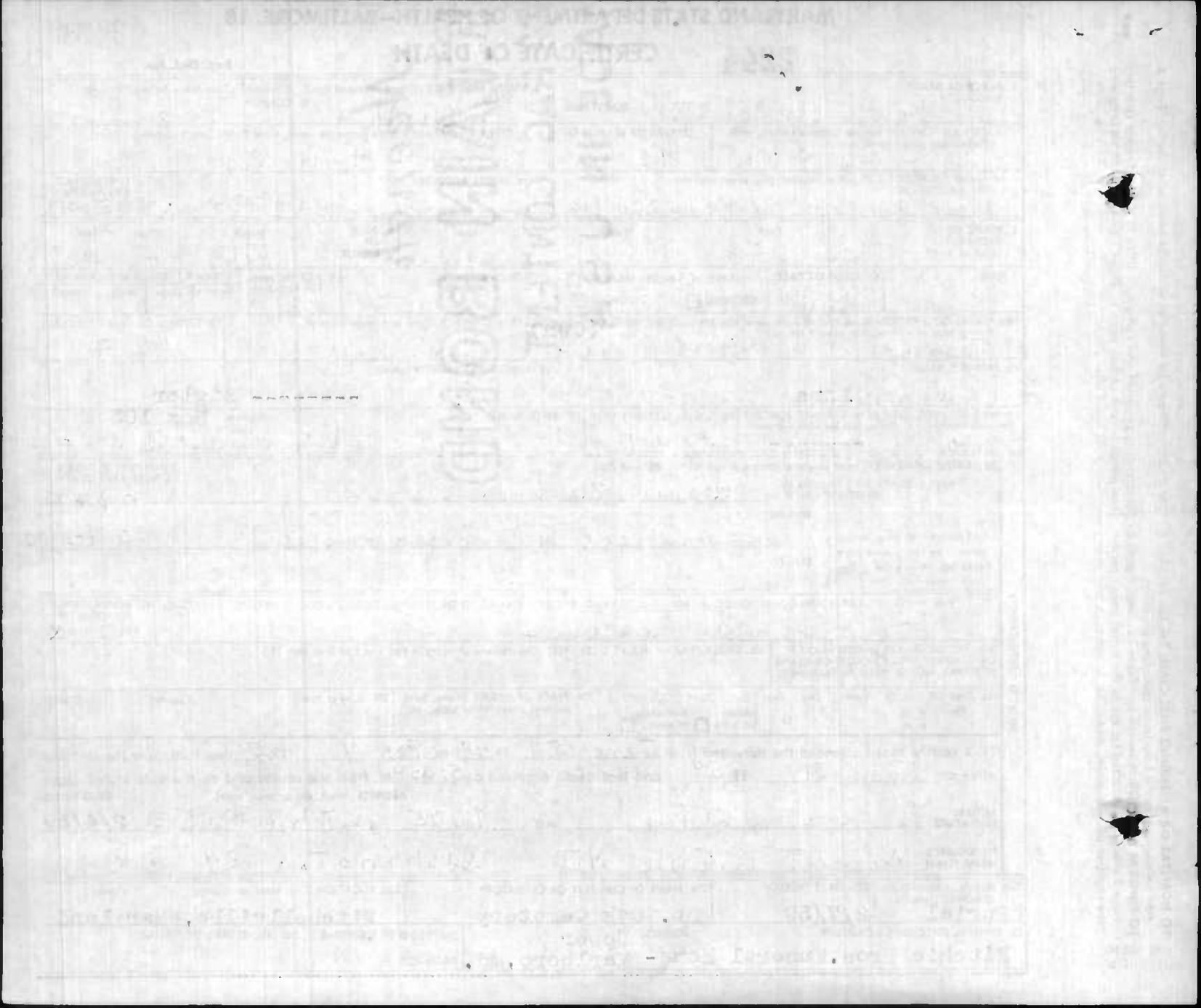
Reg. Dist. No.

02159

1. PLACE OF DEATH a. COUNTY <i>Pr Georges County</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Hall Md</i>			c. LENGTH OF STAY IN 1b <i>42 Yes</i>		
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Maryland</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Upper Marlboro Ma R.F.D #2 Box 103</i>			d. STREET ADDRESS <i>Upper Marlboro Ma R.F.D #2 Box 103</i>		
3. NAME OF DECEASED (Type or print) <i>Garland Sigler Arnold</i>			4. DATE OF DEATH Month Day Year <i>Feb 4 1959</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>June 29 1886</i>		9. AGE (In years lost birthday) yrs. <i>79</i>		10. IF UNDER 1 YEAR Months Dots Hours Min. <i>Box 103</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>			10b. KIND OF BUSINESS (Industry) <i>General Farm</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>Calvin Ezra Arnold</i>			14. MOTHER'S MAIDEN NAME <i>Alta Sigler</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>917-36-9389</i>		
17. INFORMANT <i>Mrs. Nellie Arnold, Upper Marlboro Ma R.F.D #2</i>			Address <i>Box 103</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>		
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Generalized Arteriosclerosis</i>			10 Years		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Parkinson's Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>June 15, 1949</i> , to <i>Feb 4, 1959</i> , that I last saw the deceased alive on <i>Jan 31, 1959</i> , and that death occurred at <i>5:35 PM</i> , from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <i>7005 Ritchie Rd SE Washington 27 D.C.</i>		
ACTUAL SIGNATURE <i>W. Suit Ritchie M.D.</i>			DATE SIGNED <i>2/4/59</i>		
PHYSICIAN'S NAME (Type) <i>W. Suit Ritchie M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/7/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Oak Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Mitchellville, Maryland</i>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros. Funeral Home - Marlboro, Md.</i>			24a. REC'D BY REGISTRAR DATE <i>FEB 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Oliver S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02160

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. LENGTH OF STAY IN 1b 10 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		First E.	Middle Lest BAILEY
S. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME WALTER BAILEY		14. MOTHER'S MAIDEN NAME MILLIE FAIRFAX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT DECEDEDENT
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO CEREBRAL THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CEREBRAL ARTERIOSCLEROSIS 15 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY TUBERCULOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/21 1978
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on _____, and that death occurred at _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE MOE WEISS M.D.		ADDRESS (Street, city or town, state) GLENN DALE HOSP., MARYLAND DATE SIGNED 2/21/59	
PHYSICIAN'S NAME (Type) MOE WEISS M.D.		22b. DATE THEREOF 2-24-59	
22c. NAME OF CEMETERY OR CREMATORIAL BOYDS METHODIST CH. BOYD		22d. LOCATION (City, town, or county) (State) BOYD MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE ERNEST GOLPERTINE GAULTHERSBURG, MD.		24a. REC'D BY REGISTRAR DATE FEB 25 '59	24b. REGISTRAR'S SIGNATURE ARTHUR S. KRAUS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF HAWAII

CERTIFICATE OF DEATH

RECEIVED

1960

1960

1960

1960

I, John Doe, State of Hawaii, do hereby certify that John Doe, a male, aged 35 years, died on July 1, 1960 at Honolulu, Hawaii.

RECEIVED

1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 02161			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH o. COUNTY Prince George				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland				b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 4219 Kennedy St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Emily				First Emily	Middle Jane	Last Barnes	4. DATE OF DEATH Feb 21 1959	Month Feb	Day 21	Year 1959					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Nov 1870		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At home			11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME John Walker				14. MOTHER'S MAIDEN NAME Mary McKay											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs. Ruebie B. Heironimus			Address Falls Church, Va., 6625 Willston Place,						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebra vascular accident												12 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) general hypertension												15			
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Gallatin St., Hyattsville, Md.		(State) 2/21/1959					
21. I certify that I attended the deceased from Jan 1st , 19 59 , to Feb 24th , 19 59 , that I last saw the deceased alive on Feb 24th , 19 59 , and that death occurred at 11th M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Till Bergemann															
DATE SIGNED 2/21/1959															
ACTUAL SIGNATURE Till Bergemann															
PHYSICIAN'S NAME (Type) Dr. Till Bergemann, M.D.				M.D. 4314 Gallatin St., Hyattsville, Md. 2/21/1959											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 28th, 1959				22c. NAME OF CEMETERY OR CREMATORIUM Congressional Cemetery				22d. LOCATION (City, town, or county) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS W.W. Chambers Company, Riverdale, Md.				24a. REGISTERED BY REGISTRAR DATE Arthur S. Thomas				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - CALIFORNIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2185 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02162

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Pr. Geo.	
Prince Georges MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. STREET ADDRESS Rt. 2, Box 156 A Pine Street	
3. NAME OF DECEASED (Type or print) Anthony Barowsky		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male white		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-23-1917		9. AGE (in years last birthday) 41 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. Research Corp.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Oklahoma	
13. FATHER'S NAME Stephen Barowsky		14. MOTHER'S MAIDEN NAME Stella Schalsky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes NW 2		16. SOCIAL SECURITY NO. 17. INFORMANT Address Hospital Records; Leland Memorial Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812 X DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) Laceration of inferior vena cava, laceration of liver and right kidney. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Hit by automobile	
20c. TIME OF INJURY Month, Day, Year 7:20 a.m. 2-21-59		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Laurel (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 27, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
220. BURIAL, CREMATION, REMOVAL (Specify) 226. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cem.	
Burial March 2, 1959		22d. LOCATION (City, town, or county) Laurel Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Danielson, Laurel Md.		24a. REC'D BY REGISTRAR DATE MAR 3 '59 24b. REGISTRAR'S SIGNATURE Arthur E. Trahan	

STATE OF CALIFORNIA
DEPARTMENT OF REVENUE AND TAXES

STANFORD

STATE TAXES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2190 CERTIFICATE OF DEATH

Reg. Dist. No.

02163

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Prince George				a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb		b. COUNTY Prince Georges		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		4/ Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	Last Batts	d. STREET ADDRESS 604 4th St.	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1959	9. AGE (In years last birthday) yrs. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Allen Batts		14. MOTHER'S MAIDEN NAME Dorothy Lee SKUTT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Allen Batts, 604 4th St. Laurel		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5		Address INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Cateletasis Pneumonia				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21-22-1959		20f. (City or town) Laurel	(County) (State)
21. I certify that I attended the deceased from 12-5-1959, to 12-22-1959, that I last saw the deceased alive on 21-22-1959, and that death occurred at (a) 6:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Robert C. Wingfield M.D. Laurel, Maryland PHYSICIAN'S NAME (Type) Dr. R.C. Wingfield 311 Thomas Drive Laurel, Maryland						ADDRESS (Street, city or town, State) DATE SIGNED Jan. 22 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Tony Hill Cem.		22d. LOCATION (City, town, or county) Laurel, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. M. Wingfield		ADDRESS 311 Thomas Drive Laurel, Maryland	24a. REC'D BY REGISTRAR FEB 25 '59		24b. REGISTRAR'S SIGNATURE G. C. Wingfield	

STATE OF NEVADA - BUREAU OF MOTOR VEHICLES
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 Film G238 2-11-59 et

02164

2246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George'</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George'</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Camp Springs</i> 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Camp Springs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION 5710 Allentown Road		d. STREET ADDRESS 5710 Allentown Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Barnes</i>	Middle <i>Compton</i>	Last <i>BEALL</i>
4. DATE OF DEATH	Month <i>2</i>	Day <i>3</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-7-1890</i>
9. AGE (In years lost birthday) <i>68</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
13. FATHER'S NAME <i>Richard Samuel Beall</i>	14. MOTHER'S MADDEN NAME <i>Virginia B. Crandall</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>577-24-6243</i>		17. INFORMANT <i>Richard E. Beall</i>	Address <i>Camp Springs</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Carcinoma of stomach with Metastasis to Liver 2 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-3-1958</i> to <i>2-3-1959</i> , that I last saw the deceased alive on <i>1-24-1959</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter Dillius</i>	ADDRESS (Street, city or town, state) <i>6124 Central No. Caps.</i>		
PHYSICIAN'S NAME (Type) <i>Peter DILLIUS</i>	DATE SIGNED <i>2-3-59</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/6/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Montgomery Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Codice, Aleshi, D.C.</i>	ADDRESS <i>5119 11th St. N.W.</i>	24a. REC'D BY REGISTRAR DATE <i>FEB 6 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Mann</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OF THE STATE OF TEXAS

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2191

CERTIFICATE OF DEATH

Reg. Dist. No.

02165

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 25 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 5304 Hamilton St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lester	Middle G	Last Berry	4. DATE OF DEATH Month Feb.	Day 15	Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-87	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt		10b. KIND OF BUSINESS OR INDUSTRY Printer		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elliott Berry				14. MOTHER'S MAIDEN NAME Edna ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1915 to 1916		17. INFORMANT Ida V Berry		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arterio occl. & the sl. con. art.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis & sl. disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 3717-38 H. L. Cottages, Colmar, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 58 to 2-15 , 19 59 , that I last saw the deceased alive on 2-15 , 19 59 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Cottage City, Md.							
DATE SIGNED 2-16-59							
ACTUAL SIGNATURE George Magenage							
PHYSICIAN'S NAME (Type) Dr George Magenage							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/59		22c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 19 59	
						24b. REGISTRAR'S SIGNATURE John S. K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2192

CERTIFICATE OF DEATH

Reg. Dist. No. 0216

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN b. 1 yr., & 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosa Lee Berry		First Middle Lost	4. DATE OF DEATH 2 18 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Days work	11. BIRTHPLACE (State or foreign country) Georgia
13. FATHER'S NAME Arthur Adams		14. MOTHER'S MAIDEN NAME Anna Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Decedent	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002 X DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) COR PULMONALE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		2/7, 1958, to 2/18, 1959, that I last saw the deceased	ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <i>Moe Weiss</i>	M.D.		Glen Dale Hospital 2/18/59
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	Glen Dale, Md.		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-59 (2-24-59)	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl.	22d. LOCATION (City, town, or county) Arlington, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE Palmer - Fun Home		ADDRESS 1113 H St. NW	24a. REC'D BY REGISTRAR DATE FEB 20 '59
			24b. REGISTRAR'S SIGNATURE <i>Carling & Knott</i>

STATE OF MARYLAND
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG239 2-20-59 et

02167

2193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 3401 Chatham Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cordelia		First	Middle	Last	4. DATE OF DEATH Feb. 13 1959	Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/26/1878	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME James		14. MOTHER'S MAIDEN NAME Susan Thetford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		Address 3401 Chatham Rd Hyattsville Md		
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Martha Haack		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 172 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO metastatic Adenocarcinoma (c) DUE TO Adeno carc. of the corpus uteri		INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 7 , 1959, to Feb. 13 , 1959, that I last saw the deceased alive on Feb. 13 , 1959, and that death occurred at 1:15A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3306 Rhode Island Ave., Mt. Rainier, Md.			DATE SIGNED			
ACTUAL SIGNATURE John S. Haught		M.D.						
PHYSICIAN'S NAME (Type) Dr. John S. Haught		22c. NAME OF CEMETERY OR CREMATORIAL Palem Cemetery		22d. LOCATION (City, town, or county) Towson, Maryland		(State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Feb. 17 - 59		22b. DATE THEREOF		24a. REC'D BY REGISTRAR DATE FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Weller		ADDRESS 254 Carroll St. Jr.						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF SOUTH DAKOTA TO THE STATE OF MONTANA
CERTIFICATE OF DELIVERY

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RECORDED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers, fold, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02168

2194

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.		d. STREET ADDRESS 1360 Peabody St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Baby Boy		First	Middle	Last	4. DATE OF DEATH Bourbon	Month Feb	Day 24	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22, 1959		9. AGE (In years lost birthday) yrs. 1 IF UNDER 1 YEAR IF UNDER 24 HRS.	Months 2	Days 18	Hours 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Newborn		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A./		
13. FATHER'S NAME John Bourbon				14. MOTHER'S MAIDEN NAME Mary Winifred McBride				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 756.2		16. SOCIAL SECURITY NO.		17. INFORMANT Parents		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sept 16 gastric contents + ateletas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2-22-59 to 2-24-59 , that I last saw the deceased alive on 2-22-59 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE A Deitz		M.D.		ADDRESS (Street, city or town, state) Hyattsville Md.		DATE SIGNED Feb 22 1959		
PHYSICIAN'S NAME (Type) A Deitz								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/59		22c. NAME OF CEMETERY OR Crematory Washington National		22d. LOCATION (City, town, or county) (State) Suitland Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons Hyattsville Md.				ADDRESS		24a. REC'D BY REGISTRAR Mar 2 1959		
						24b. REGISTRAR'S SIGNATURE Gasch's Sons		

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02169

2247

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Hill</i>		d. LENGTH OF STAY IN lb 27 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4611- Branch Avenue</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Hill</i>	
e. STREET ADDRESS <i>14611- Branch Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ellen Catherine Boyd</i>		First <i>Ellen</i>	Middle <i>Catherine</i>
4. DATE OF DEATH <i>Feb 14 1959</i>		Last <i>Boyd</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14, 1874</i>
9. AGE (In years from birthday) <i>84</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Bolger</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>233-44-0682</i>	
17. INFORMANT <i>William C. Boyd Wash D.C.</i>		Address <i>233-44-0682</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i>			
442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular renal disease</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>James I. Boyd</i>		DATE SIGNED <i>Feb 14, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2-17-1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. OLIVET</i>		22d. LOCATION (City, town, or county) <i>WASHINGTON D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>LEE FUNERAL HOME 300 4th St. NE</i>		24a. REC'D BY REGISTRAR <i>FEB 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harrel</i>
ADDRESS		DATE	

STATE
REGISTRATION
NUMBER

MEXICAN EXAMINER'S CERTIFICATE OF DEATH

NAME OF MEXICAN EXAMINER

NAME OF MEXICAN

DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 9, 10, 13, 14 Film G239 3-4-59 et

2195

CERTIFICATE OF DEATH

Reg. Dist. No.

02170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days		15. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5704 Hamilton Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Erad Beale Brann		First	Middle	Lost	4. DATE OF DEATH Month Day Year February 25 19 59	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/90	9. AGE (In years lost birthday) 69/68 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 68	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME James Payne Brann		14. MOTHER'S MAIDEN NAME Lena Dunaway Brann							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy D. Daughter		Address Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		<i>Hepatocarcis</i>		<i>Genchogenic Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farnham, Virginia		20f. (City or town) Farnham		(County) Virginia	(State) Virginia
21. I certify that I attended the deceased from 2/23/59 to 2/25/59 , that I last saw the deceased alive on February 25, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 3408 Rhode Island Ave Mt. Ranier, Md.			DATE SIGNED
ACTUAL SIGNATURE Leon R. Levitsky, M.D.									
PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORIUM Baptist Ch. Cemetery		22d. LOCATION (City, town, or county) Farnham, Virginia		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE DC3		24a. REC'D BY REGISTRAR FEB 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

BY THE GOVERNMENT OF THE UNITED STATES OF AMERICA

POSTAGE PAID



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2248

CERTIFICATE OF DEATH

Reg. Dist. No. 0217

1. PLACE OF DEATH a. COUNTY <i>Prince Geo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine, Rural</i>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <i>Brandywine, Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Rose</i>	Middle <i>ELLA</i>	Last <i>Brauner</i>
4. DATE OF DEATH	Month <i>Feb.</i>	Day <i>22</i>	Year <i>1959</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 20 1846</i>
9. AGE (In years lost birthday) 112 yrs.	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>12</i>	12. IF UNDER 24 HRS. Hours <i>11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>R. Hawkins</i>	14. MOTHER'S MAIDEN NAME <i>Jane Hawkins</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>	16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT <i>Peter Moore, Brandywine Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>421.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Chemie Endocardial & myocard. Failure Years.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
(b) DUE TO <i>Senescence</i>			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Asbury M.E.</i>
20f. (City or town) <i>Brandywine, Md.</i>		(County)	(State)
21. I certify that I attended the deceased from <i>Feb 9</i> , 19 <i>59</i> , to <i>Feb 22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Feb 19</i> , 19 <i>59</i> , and that death occurred at <i>2:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Valeh M. Seron</i>		ADDRESS (Street, city or town, state) <i>Brandywine, Md.</i>	DATE SIGNED <i>2/23/59</i>
PHYSICIAN'S NAME (Type) <i>VAHEH M. SERON MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb. 25 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Asbury M.E.</i>	22d. LOCATION (City, town, or county) <i>Brandywine, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hugh Funeral Home</i>		ADDRESS <i>Waldorf, Md.</i>	24a. REC'D BY REGISTRAR DATE FEB 27 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF HAWAII - BUREAU OF HEATH

CERTIFICATE OF DEATH

SEARCHED

INDEXED

SERIALIZED

FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2196

CERTIFICATE OF DEATH

Reg. Dist. No. 02172

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) cheverly		c. LENGTH OF STAY IN lb 4$\frac{1}{2}$ Hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 8134 Penbrook Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elijah	Middle	Last Breeden	4. DATE OF DEATH	Month Feb.	Day 16	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 12, 1924	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Frozen Food Lockers		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Breeden		14. MOTHER'S MAIDEN NAME Clara ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Kathryn Breeden		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO <i>Generalized Cancerous tumors</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Carcinoma of Stomach</i> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) (State)			
21. I certify that I attended the deceased from 2-4 , 19 57 to 2-16 , 19 57 , that I last saw the deceased alive on 2-15 , 19 57 , and that death occurred at 10:30A.M. from the causes and on the date stated above. ACTUAL SIGNATURE O. Dietz M.D. ADDRESS (Street, city or town, state) 4314 Gallatin St. DATE SIGNED Hyattsville Md.							
PHYSICIAN'S NAME (Type) Dr. Aaron Dietz		22d. LOCATION (City, town, or county) Arlington Va. (State)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

BY COMMISSIONER OF THE STATE OF OHIO

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
John Doe	50	M	Heart Disease
Spouse	Age	Sex	Relationship
Jane Doe	45	F	Daughter
Children	Age	Sex	Relationship
John Jr.	25	M	Son
Jane Jr.	22	F	Son
Parents	Age	Sex	Relationship
John Sr.	80	M	Father
Jane Sr.	75	F	Mother
Other Relative	Age	Sex	Relationship
John Doe Jr.	15	M	Son
Jane Doe Jr.	13	F	Son
Witnesses	Signature	Date	
John Doe	John Doe	10/10/2023	
Jane Doe	Jane Doe	10/10/2023	
Official Seal	Official Seal	Official Seal	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2172

CERTIFICATE OF DEATH

Reg. Dist. No.

02173

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home	d. STREET ADDRESS 5805 Queens Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ella C. Brennan	First	Middle	Last
4. DATE OF DEATH Month Feb Day 21 Year 1959			
5. SEX Female White	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Mar. 8, 1873
8. AGE (In years old at birthday) 85 yrs.	9. IF UNDER 1 YEAR Months 0 Days 0	10. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY/ USA	
13. FATHER'S NAME Edward Brennan		14. MOTHER'S MAIDEN NAME Catherine Toumey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Address Records at Sacred Heart Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 14 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/21, 1953, to 2/21, 1959, that I last saw the deceased alive on Feb 19, 1959, and that death occurred at 3:10 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 322 H St. N.E. DATE SIGNED ACTUAL SIGNATURE Thomas F. Collins 2/21/59			
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/59	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR FEB 24 1959 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DESIGN

1 2 3 4
5 6 7 8 9
10 11 12 13 14
15 16 17 18 19
20 21 22 23 24
25 26 27 28 29
30 31 32 33 34
35 36 37 38 39
40 41 42 43 44
45 46 47 48 49
50 51 52 53 54
55 56 57 58 59
50 51 52 53 54
55 56 57 58 59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-238 2/13/59, c.c.

2170

CERTIFICATE OF DEATH

Reg. Dist. No.

02174

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Illinois</i> b. COUNTY <i>Illinois</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#7 Austin Court</i>		e. STREET ADDRESS <i>1/14</i>			
3. NAME OF DECEASED (Type or print) GERALD		First C , Middle A , Last BRISTOW	4. DATE OF DEATH PEB 8 1959		
5. SEX H	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905 <i>12 Jan 1903</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weather Bureau		10b. KIND OF BUSINESS OR INDUSTRY U S Government	11. BIRTHPLACE (State or foreign country) Illinois		
13. FATHER'S NAME William R Bristow		14. MOTHER'S MAIDEN NAME Pearl C ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Charlotte V. Bristow		
			Address College Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Deabetes Mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 47 1/2 - Brywyn Rd	20f. (City or town) Colmar Manor, Md.	(County)	(State)
21. I certify that I attended the deceased from Jan 31 1959 to Feb 8 1959 , that I last saw the deceased alive on Feb 8 1959 , and that death occurred at 5A M, from the causes and on the date stated above. ACTUAL SIGNATURE Ed. Steine M.D. ADDRESS (Street, city or town, state) 47 1/2 - Brywyn Rd DATE SIGNED 2/8/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Feb 10, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR FEB 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. King		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

01-3000000 - REACH TO TERRITORY STATE GOVERNMENT

HIGHWAY STABILIZED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2249

CERTIFICATE OF DEATH

Reg. Dist. No.

02175

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AF Base		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (27)		d. STREET ADDRESS 501 73 Place		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John		First Middle Payne		Lost Butler		4. DATE OF DEATH February	Month 5	Day Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 September 1887	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John P Butler			14. MOTHER'S MAIDEN NAME Mattie Payne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420-14-9760		17. INFORMANT Myrtle G Wetzel		Address 501 73 Place Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident and Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 16 Days		
33/x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Arteriosclerosis								
DUE TO } DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 21 Jan 1959, to 5 Feb 1959, that I last saw the deceased alive on 5 Feb 1959, and that death occurred at 4:25 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Reginald P McManus</i> PHYSICIAN'S NAME (Type) REGINALD P MCMANUS CAPT USAF (MC)			ADDRESS (Street, city or town, state) USAF Hospital Andrews			DATE SIGNED 5 Feb 59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/59		22c. NAME OF CEMETERY OR CREMATORIUM Greenwood Cemetery		22d. LOCATION (City, town, or county) Montgomery Alabama (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lees Sons			ADDRESS 4th & Mass Ave. N.E. Washington D.C.			24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02176

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 HR - 40 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 4716 41 Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie		First Byrd Middle Carrie		4. DATE OF DEATH Month February Day 2 Year 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10/19/06		9. AGE (In years lost birthday) yrs. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas Cheve		14. MOTHER'S MAIDEN NAME Sallie Haldin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sherman Husband		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Acute Coronary Infarction				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2724 74th Ave.		20f. (City or town) (County) (State) Hyattsville Md.	
21. I certify that I attended the deceased from Jn. N. 20, 1959 , to Feb. 2, 1959 that I last saw the deceased alive on February 2, 1959 , and that death occurred at 3:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2724 74th Ave. DATE SIGNED Till Bergman							
ACTUAL SIGNATURE Till Bergman		PHYSICIAN'S NAME (Type) Dr. Till Bergman		DATE SIGNED 2/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-6-59		22b. DATE THEREOF 2-6-59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington		ADDRESS 467 N St NW		24a. REC'D BY REGISTRAR DATE FEB 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

DEPARTMENT OF STATE QUADRATIC

CERTIFICATE OF DEATH

✓ ✓ ✓

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G240, 3/18/59 fcy

CERTIFICATE OF DEATH

02177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) ORNITHOTON Prince George General Hospital		e. STREET ADDRESS 5350 Quincey Place	
3. NAME OF DECEASED John First J. Middle CANTY Lost		4. DATE OF DEATH Feb. Month 18 Year 59 19	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1892
9. AGE (In years last birthday) 676 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME P.H. CANTY		14. MOTHER'S MAIDEN NAME Mary A. Horrigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.I		16. SOCIAL SECURITY NO. 577-50-6260 17. INFORMANT Lillian E. CANTY-wife Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 1 w/e		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Ruptured aortic aneurysm 1 w/e		(c) DUE TO Atherosclerotic Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 9, 1959, to Feb. 16, 1959, that I last saw the deceased alive on Feb. 16, 1959, and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 3308 Perry St., Mt. Rainier, Md. DATE SIGNED ACTUAL SIGNATURE C. C. Hageage 2/17/59 PHYSICIAN'S NAME (Type) C. C. Hageage M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 12/19/59		22c. NAME OF CEMETERY OR CREMATORIAL Arl Nat. Cem.	
22d. LOCATION (City, town, or county) (State) Arlington, Va.		24a. REC'D BY REGISTRAR DATE 2/20/59	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee's Sons Co.		24b. REGISTRAR'S SIGNATURE C. C. Hageage	
ADDRESS 300-4th St. N.E.			

WISCONSIN STATE DEPARTMENT OF HEALTH - BIRTHING 10

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02178

1		2199		2					
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		3			
1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 14		d. STREET ADDRESS 5017 Kenesaw Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	Last Carter	4. DATE OF DEATH February 11 1959	Month February	Day 11	Year 1959	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/59	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 9	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME William J. Carter				14. MOTHER'S MAIDEN NAME Mary L.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary L. Carter Mother		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.7 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cancer (c) DUE TO Pulmonary Stenosis						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4506 College Ave		20f. (City or town) College Park		(County) Md.	(State) Md.
21. I certify that I attended the deceased from February 9, 1959 , to February 11, 1959 , that I last saw the deceased alive on February 11, 1959 , and that death occurred at 8:50A M , from the causes and on the date stated above.						ADDRESS (Street, city or town, Note) 4506 College Ave			DATE SIGNED 2/12/59
ACTUAL SIGNATURE Dr. Louis Mendel		M.D.							
PHYSICIAN'S NAME (Type) Dr. Mendel									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		22d. LOCATION (City, town, or county) Washington D. C.		(State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		ADDRESS		24a. REGD BY REGISTRAR FEB 16 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
				DATE					

CERTIFICATE OF DESIGN

1940



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2250 CERTIFICATE OF DEATH

Reg. Dist. No. 02179

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 2 yrs., 2 mos. & 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Raymond	Middle B.	Last Carver
4. DATE OF DEATH	Month 2	Day 3	Year 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1893
9. AGE (In years last birthday) yrs. 65	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter	11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles L. Carver	14. MOTHER'S MAIDEN NAME Marie J. Carter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 719-07-0349	17. INFORMANT Decedent	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bronchogenic carcinoma, right lung			INTERVAL BETWEEN ONSET AND DEATH 16 months
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ DUE TO _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Pulmonary tuberculosis, 15 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/30 , 19 56 to 2/3 , 19 59 , that I last saw the deceased alive on 2/3 , 19 59 , and that death occurred at 10:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Moe Weiss</i>	M.D.	ADDRESS (Street, city or town, state) Glenn Dale Hospital	DATE SIGNED 2/3/59
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	Glenn Dale, Md.		
22a. BURIAL CREMATION, REMOVAL (Specify) 2-7-59	22b. DATE THEREOF 2-7-59	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Joyner</i>	ADDRESS <i>116 Massachusetts St. W.</i>	24a. REC'D BY REGISTRAR FEB 9 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Krasa</i>

CERTIFICATE OF DEATH

6280

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2200

CERTIFICATE OF DEATH

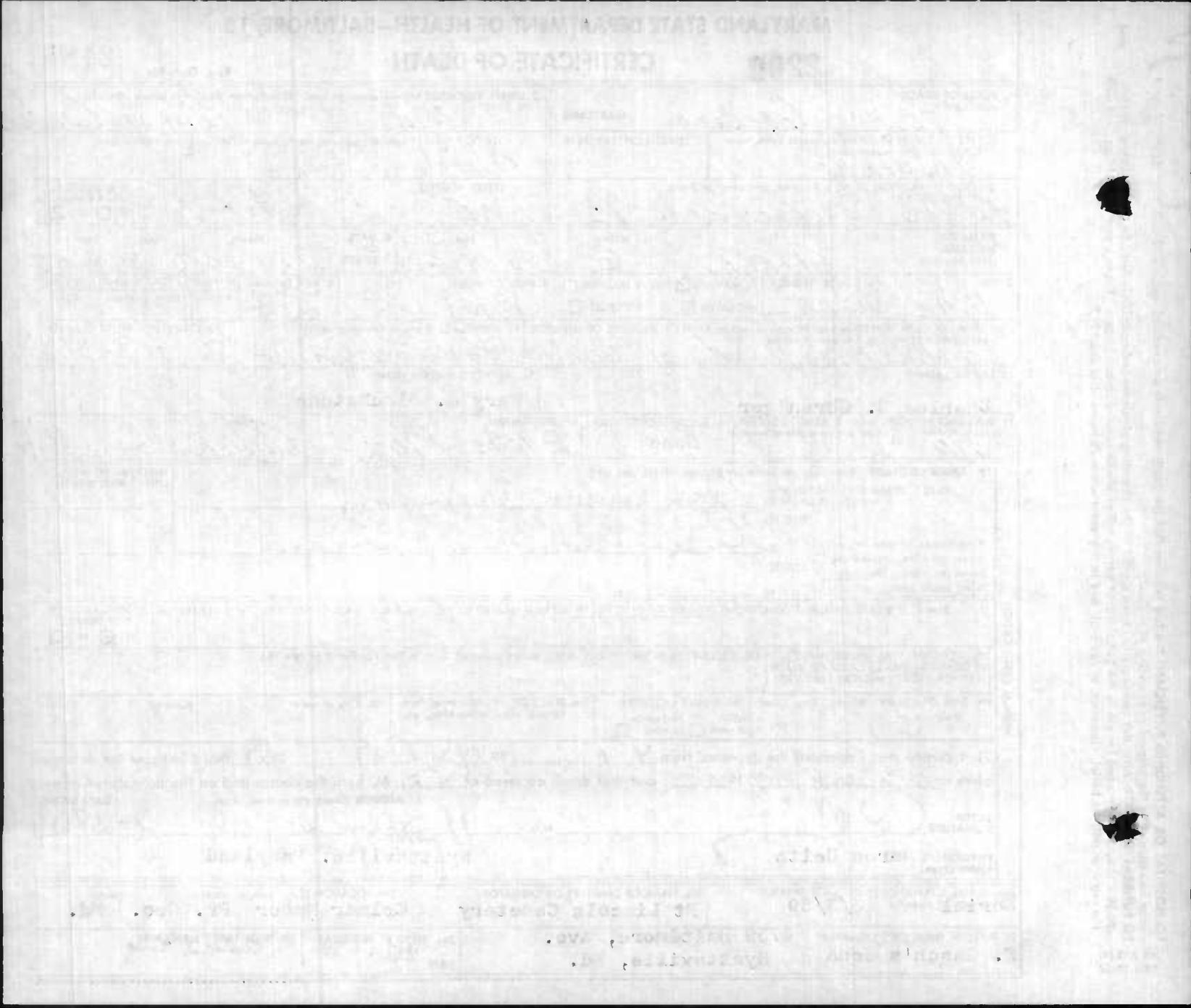
Reg. Dist. No.

02180

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY <i>Prince George</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i>							
c. LENGTH OF STAY IN lb <i>6 months</i>		d. STREET ADDRESS <i>14305 51 Street</i>							
d. NAME OF DECEASED (Type or print) <i>ALFRED G. CHRONIGER</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. SEX <i>Male</i>	4. FIRST MIDDLE LAST SR. <i>ALFRED G. CHRONIGER</i>	5. DATE OF DEATH <i>February 27 1959</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/21/95</i>	9. AGE (In years last birthday) <i>63 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Building Trades Naval Corp</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>United States</i>
13. FATHER'S NAME <i>Charles B. Chroniger</i>	14. MOTHER'S MAIDEN NAME <i>Mary J. Blackstone</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Elsie May - Address same-Wife</i>	Address <i>420.0</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cate Cervical Thrombosis,</i> DUE TO <i>Acute Ischemic Heart Disease</i>					INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Acute Ischemic Heart Disease</i> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Hyattsville</i>	(County) <i>Md.</i>	(State) <i>Md.</i>				
21. I certify that I attended the deceased from <i>4-1</i> , 19 <i>44</i> , to <i>2-27</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>February 27 1959</i> , and that death occurred at <i>30</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. Deitz</i>						ADDRESS (Street, city or town, state) <i>Hyattsville, Maryland</i>	DATE SIGNED <i>2-27-59</i>		
PHYSICIAN'S NAME (Type) <i>Aaron Deitz</i>	M.D.								
22a. BURIAL, CREMATION, Burial (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/3/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) <i>Colmar Manor Pr. Geo.</i>	(State) <i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>	4739 Baltimore Ave. Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE <i>MAR 4 1959</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Moore</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2201

CERTIFICATE OF DEATH

Reg. Dist. No.

02181

1		M		76		1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.			
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.											
1. PLACE OF DEATH a. COUNTY		Prince Geo Co		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Riverdale Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Eugene Leland Memorial		17 days		d. STREET ADDRESS		Montgomery			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.			
F		W		3-17-81		77 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Own home		Md.		Md.		26. 5.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
George Alfred Scaggs		Sarah Frances Harding.									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no				Record Office 4408 Queensbury Rd		Riverside					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral vascular accident						5 hours			
33IX		DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)									
{		DUE TO									
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Recent pneumonia									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Jan 15, 1959, to Feb 8, 1959, that I last saw the deceased alive on Feb 8, 1959, and that death occurred at 11 P.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE		John N. Andrews		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (TYPE)		John N. Andrews		9601 Colesville Rd		Silver Spring Md		2-9-59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
BURIAL		3/11/59		Mt. Zion Cemetery		Highland, Montgomery Co., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
WARNER E. PUMPHREY, INC.		SILVER SPRING, MD.		DATE FEB 11 '59		Arthur S. Kraus					
Reynard G. Baska											

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE
EDWARD J. HANLEY	60	M	APRIL 10, 1950
ADDRESS OF DECEASED			
100 W. CHURCH ST., BURLINGTON, Vt.			
NAME AND ADDRESS OF PHYSICIAN			
DR. RICHARD L. COOPER, 100 W. CHURCH ST., BURLINGTON, Vt.			
NAME AND ADDRESS OF FUNERAL DIRECTOR			
WILLIAM C. COOPER, 100 W. CHURCH ST., BURLINGTON, Vt.			
CAUSE OF DEATH			
HEART DISEASE			
TIME OF DEATH			
10:00 A.M.			
TIME OF AUTOPSY			
10:00 A.M.			
NAME OF PERSON SIGNING			
JOHN COOPER, M.D.			
SIGNATURE			
BURLINGTON, Vt.			
APRIL 10, 1950			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Health Department.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02182

2202

1. PLACE OF DEATH a. COUNTY <i>Prince George's County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>H. Sec</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges Gen Hosp</i>		e. STREET ADDRESS <i>916-64th Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Robert Lee Clayton</i>		First <i>Robert</i>	Middle <i>Lee</i>
4. DATE OF DEATH <i>2-8-1959</i>		Last <i>Clayton</i>	Month Year Day
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 29, 1927</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Gwendolyn P. Clayton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mother Same address as #2</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Bronchopneumonia</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John J. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John J. MALONEY - M.D.</i>		DATE SIGNED <i>Feb. 8, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>2-11-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry J. Washington</i>		ADDRESS <i>467 N St NW</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

EXAMINER'S STATEMENT OF THE STATE OF THE EXAMINER'S INFORMATION

STATE
FEDERAL

EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2203

CERTIFICATE OF DEATH

Reg. Dist. No.

02183

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 5502 Farragut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Theodore	Middle Graham	Last Coffey	4. DATE OF DEATH Feb. 3 1959	Month Feb.	Day 3	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 29 Dec. 1884	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR 1 Months	IF UNDER 24 HRS. 2 Days	Hours Min. 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Equipment Sales		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Theodore Coffey		14. MOTHER'S MAIDEN NAME Nellie W. Graham					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 289-01-7334		17. INFORMANT Theodore G. Coffey-son-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5870 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Aspiration & Gastric contents DUE TO (c) Acute pancreatitis							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-28 , 19 59 , to 2-3 , 19 59 , that I last saw the deceased alive on 2-3 , 19 59 , and that death occurred at 1,15A M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. 3711-38th St. Cottages DATE SIGNED 2-3-59							
ACTUAL SIGNATURE George J Hageage		PHYSICIAN'S NAME (Type) George J Hageage 3717-38th St. Cottage City, Md.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/59		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE - STATE OF HERTFORDSHIRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18-21 Film 239 2-27-59 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

02184

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 2-11-59 11:00 AM		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland		c. STREET ADDRESS Box 307 High Ridge Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Land Memorial Hospital		d. STREET ADDRESS Box 307 High Ridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Aloysius		First James	Middle Aloysius	Last Cook	4. DATE OF DEATH February 17 1959	Month February	Day 17	Year 1959	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 8-22-76	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Night Watchman U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Cook		14. MOTHER'S MAIDEN NAME Julia Johnson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary A. Souder Box 307 High Ridge Rd. and Niece		Address			
no									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0		DUE TO Jurying to head		Cerebral (Subdural Hematoma)		INTERVAL BETWEEN ONSET AND DEATH 2-3-days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { Due to Fall		(b) Fall							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home striking back of head (Occiput)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Laurel		(County) Howard	(State) Maryland
21. I certify that I attended the deceased from January 14, 1959 to February 17, 1959 that I last saw the deceased alive on January 14, 1959 , and that death occurred on February 17, 1959 at Laurel, Md. from the causes and on the date stated above. ACTUAL SIGNATURE Robert C. Wingfield M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb 20, 1959		22b. DATE THEREOF Emmanuel Cemetery		22c. NAME OF CEMETERY OR CREMATORIAL Scaggsville, Md.		22d. LOCATION (City, town, or county) Scaggsville, Md.		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Heath Funeral Home Laurel Md		ADDRESS		24a. REC'D. BY REGISTRAR FEB 25 1959		24b. REGISTRAR'S SIGNATURE John J. Morris			
VS A15 (4) 15M 9/55				DATE					

BY BROOKFIELD STATE BANK
CERTIFICATE OF DEATH

CHAS. L.

X

SEARCHED INDEXED SERIALIZED FILED
JULY 1 1968
BROOKFIELD STATE BANK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2205

CERTIFICATE OF DEATH

Reg. Dist. No. 02185

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills</i>			
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <i>Prince Georges General Hosp</i>		e. STREET ADDRESS <i>16916 Defense Highway</i>		f. DATE OF DEATH <i>Feb 20 1959</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>ANNA</i>	Middle <i>M.</i>	Last <i>CORY</i>	Month <i>Feb</i>	Day <i>20</i>	Year <i>1959</i>	
4. SEX <i>Female</i>	5. COLOR OR RACE <i>white</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>5/4/85</i>	8. AGE (In years last birthday) <i>73</i>	9. IF UNDER 1 YEAR Months <i>0</i>	10. IF UNDER 24 HRS. Days <i>0</i>	11. HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Belgium</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Matthew Patteet</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Le Levre</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>443X</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Robert P. Cory</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMMORHAGE</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(b) HYPERTENSIVE ARTERIOSCLEROTIC DISEASE</i>		DUE TO <i>(c) CARDIO- VASCULAR DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 1/2 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						20. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ July 1956, to 20 Feb 1959, that I last saw the deceased alive on 20 Feb 1959, and that death occurred at 1:30 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>Thomas J. Maloney</i>		M.D. 4814-71st Ave.					
PHYSICIAN'S NAME (Type) <i>THOMAS G. MALONEY</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/23/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malloy's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. ...</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02186

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		d. STREET ADDRESS 4816 Meadow View	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Lost Crombie	4. DATE OF DEATH 2	Month 2	Day 21	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1959	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Newborn		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Bartholemew Crombie Jr.		14. MOTHER'S MAIDEN NAME Rosa Stewart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 762.5		16. SOCIAL SECURITY NO.		17. INFORMANT Parents		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO <i>Affectasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Prematurity</i> (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/19/59 to 2/21/59 that I last saw the deceased alive on 2/21/59 , and that death occurred at 1:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John W. Perkins</i>		ADDRESS (Street, city or town, state) M.D. 5301 Haught St., Pittsburgh, Pa.		DATE SIGNED 2/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryan, Inc.</i>		ADDRESS 317 Pa. Ave., SE DC3		24a. REC'D BY REGISTRAR FEB 27 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2251

CERTIFICATE OF DEATH

Reg. Dist. No.

02187

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AF Base		c. LENGTH OF STAY IN 1b		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 27	
				d. STREET ADDRESS 4816 V Street S E	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Paul	Middle Matthew	Last D'Antuono	4. DATE OF DEATH February 10 1959
5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 August 1919	9. AGE (In years lost/birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY USAF Band		11. BIRTHPLACE (State or foreign country) Washington D. C.	
13. FATHER'S NAME Matteo D'Antuono		14. MOTHER'S MAIDEN NAME Santa Norcio		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 41 - 45 577-16-5553		17. INFORMANT Official Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address Wound Frontal of Head			
976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Bullet self inflicted small arms weapon		INTERVAL BETWEEN ONSET AND DEATH Immediate			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Small arms weapon placed against forehead			
20c. TIME OF INJURY Hour a. m. 1028 p. m.		Month, Day, Year Feb 10 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US Air Force Base	20f. (City or town) Andrews AFB, Washington D C
20g. (County)		(State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1028 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Andrews Air Force Base					
ACTUAL SIGNATURE <i>Marvin E. Haskin</i>		DATE SIGNED 10 Feb 59			
PHYSICIAN'S NAME (Type) MARVIN E HASKIN CAPT USAF (MC)		M.D. USAF Hospital Andrews			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		22d. LOCATION (City, town, or county) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. J. Rinaldi</i>		ADDRESS Rinaldi Funeral Home, Inc. 816 H St., N.E., Wash. 2, D. C.		24a. REC'D BY REGISTRAR FEB 16 '59 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

В этом разделе вы можете ознакомиться с общими сведениями о том, каким образом можно участвовать в конкурсе.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG239 2-20-59 et

2173

CERTIFICATE OF DEATH

Reg. Dist. No.

112188

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 mon 9days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rest Home 5801--42nd Ave., Hyattsville Conv. &		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis (Rural)	
3. NAME OF DECEASED (Type or print) ALVIN		4. DATE OF DEATH First Middle Day Month Day Year HENRY DAY February 13th, 19 59	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 3rd, 1869	
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 0 2 X - 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Pressman		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Eng. & Printing	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Bideon Day		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Austin W. Day, 4821 Rhode Island Ave., Hyattsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Pustular hypertension. supra fulic cystotomy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 8:15 P.M.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-28 , 19 58 , to 2-13 , 19 59 , that I last saw the deceased alive on 2-13-59 , 19 59 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE John P. Clum PHYSICIAN'S NAME (Type) John P. Clum		ADDRESS (Street, city or town, state) 6110--43rd Ave., Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 17th, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Columbia Gardens Cemetery		22d. LOCATION (City, town, or county) Arlington, Arlington Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2207

CERTIFICATE OF DEATH

Reg. Dist. No. 02180

1. PLACE OF DEATH a. COUNTRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
Prince George County MARYLAND		Maryland Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Riverdale	13 days	X Landover		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
Beland Memorial Hosp	9015 Ardmore Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
	Thomas	Frankie	Dean	
4. DATE OF DEATH	Month	Day	Year	
	Feb	5	1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-23-'78	
8. AGE (In years last birthday) yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	11. IF UNDER 24 HRS. Hours	
81				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Mechanic Retired		D.C.	U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
Thomas Dean Sr	Margaret Trade			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
No	none	Hospital Record		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis 2 weeks			
420.0	DUE TO	Arterio-sclerotic heart disease 3 mths.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)	DUE TO			
	(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from Jan 24, 1959, to Feb 5, 1959, that I last saw the deceased alive on Feb 5, 1959, and that death occurred at 3 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE L W Malin M.D.	Riverdale, Md		2-5-59	
PHYSICIAN'S NAME (Type)	L W Malin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/59	22c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet Cemetery	22d. LOCATION (City, town, or county) Washington D. C.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR FEB 9 '59	24b. REGISTRAR'S SIGNATURE Arthur J. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1933

DEATH

REGISTRATION

SEARCHED

INDEXED

FILED

SERIALIZED

STAMPED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2208

CERTIFICATE OF DEATH

Reg. Dist. No.

02190

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Highbridge Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ruth	Middle R	Last De Bow	4. DATE OF DEATH Feb. 5 1959	Month Feb.	Day 5	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 17 1907		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert J Roberts Sr.				14. MOTHER'S MAIDEN NAME Mabel L. Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband Zacheus L De Bow		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Myocardial Infarction Dumb to the occ. part des. b. left as. Act.							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) RFD Bowie 2nd	(County) Colmar Manor, Md.
21. I certify that I attended the deceased from 2/3 , 19 59 , to 2/5 , 19 59 , that I last saw the deceased alive on 2/4 , 19 59 , and that death occurred at 3:45A M, from the causes and on the date stated above. ACTUAL SIGNATURE Harold J Kurtz							
ADDRESS (Street, city or town, state) 2/5/59							
DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. Harold J Kurtz							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 7, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Feb 9 1959	
						24b. REGISTRAR'S SIGNATURE John K. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07. 2007.08.01 - 2007.08.02 07. 2007.08.01 - 2007.08.02

07. 2007.08.01 - 2007.08.02 07. 2007.08.01 - 2007.08.02

3

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2174

CERTIFICATE OF DEATH

Reg. Dist. No.

02191

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	c. LENGTH OF STAY IN 1b 15	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5218 42th Place		d. STREET ADDRESS 5218 42th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ellen Denger	4. DATE OF DEATH February 8, 1959	Month February	Day 8
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 5, 1880
9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY own home	12. BIRTHPLACE (State or foreign country) Ohio
13. FATHER'S NAME Norman N Hill	14. MOTHER'S MAIDEN NAME Alice Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Barbara D. Gibson	Address Hyattsville Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ACUTE CEREBROVASCULAR HEMORRHAGE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 FEB. , 1957, to 8 FEB. , 1957, that I last saw the deceased alive on 3 FEB. , 1959, and that death occurred at 2:01 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 905 Cox Ave, Hyattsville 2857	
ACTUAL SIGNATURE Henry R. Wolfe	DATE SIGNED 2/10/59		
PHYSICIAN'S NAME (Type) Henry R. Wolfe	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF 2/10/59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville Maryland.	24a. REC'D BY REGISTRAR DATE FEB 10 '59	24b. REGISTRAR'S SIGNATURE Cirthur L. Kinney

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2209

CERTIFICATE OF DEATH

Reg. Dist. No.

02192

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 7747 Frederick Road						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Stephen		First	Middle	Last	4. DATE OF DEATH February 6, 1959	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/01		9. AGE (In years lost birthday) yrs. 57	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME Stephen Doyle		14. MOTHER'S MAIDEN NAME Margaret Maxwell								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 402-18-8548		17. INFORMANT Amelia L. Wife		Address Address same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 582X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Ateloc fan's both lower lobe Asp. Gastre contract Hernia abscess.										
INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 3306 Rhode Island Ave. Mt. Ranier Md.		(State)		
21. I certify that I attended the deceased from January 18, 1959 , to February 6, 1959 , that I last saw the deceased alive on February 6, 1959 , and that death occurred at 8:50A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3306 Rhode Island Ave. Mt. Ranier Md. DATE SIGNED William B. Hagan M.D.										
ACTUAL SIGNATURE William B. Hagan		DATE SIGNED								
PHYSICIAN'S NAME (Type) William B. Hagan										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9th, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cem.		22d. LOCATION (City, town, or county) Suitland Rd. Pr. Geo. Co., Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber's Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Traub				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

STATE OF MICHIGAN - DIVISION OF
CENSUS - CERTIFICATE OF DESIGN



DETROIT, MICHIGAN - APRIL 1930

14
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

02193

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M.3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Pearce Georges Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pearce Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights, Maryland</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Spring Fair Store</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charlie C. Dunlop</i>		First <i>Charlie</i>	Middle <i>C.</i>
4. DATE OF DEATH <i>Feb 28 1959</i>		Lost <i>Never</i>	Month <i>Feb</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Nov 7, 1897</i>		9. AGE (In years from birthday) <i>61 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier U.S.A. Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Rockingham, North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank S. Dunlop</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Welch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Address 417 Grandin Rd</i>	
17. INFORMANT <i>Grace Covington (Sister)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary occlusion</i> <i>Cardiovascular renal disease</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James J. Boyd</i>		DATE SIGNED <i>March 1, 1959</i>	
EXAMINER'S NAME (Type) <i>James J. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
220. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-4-1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NATIONAL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home 300 4th St NE</i>		24a. REC'D BY REGISTRAR DATE MAR 4 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

THE STATE OF MICHIGAN
DEPARTMENT OF STATE EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2210

CERTIFICATE OF DEATH

Reg. Dist. No. 02194

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Hrs 35 Min		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 4318 34th St.		e. STREET ADDRESS 34					
3. NAME OF DECEASED (Type or print) Christian		First	Middle	Last	4. DATE OF DEATH February 11	Month	Day	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5-21-73	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Lenhardt Eckert				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Helena Wilson		Address Brentwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized CANCINOMATOSIS DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO BRONCHIAL CARCINOMA. (c)									
INTERVAL BETWEEN ONSET AND DEATH 7 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Riverdale		(County) Riverdale	(State) Md.
21. I certify that I attended the deceased from 2-13-1959 to 2-14-1959 , that I last saw the deceased alive on 2-14-1959 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Albert Roth									
PHYSICIAN'S NAME (Type) Dr. Albert Roth									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cemetery		22d. LOCATION (City, town, or county) Washington D. C.			
(State) Md.									
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR FEB 17 '59		24b. REGISTRAR'S SIGNATURE Carrie S. Knapp			

STATE DEPARTMENT OF THE NAVY - BUREAUS
CERTIFICATE OF DEATH

DEATH CERTIFICATE
No. 1234567890
Date of Birth: 10/10/1900
Place of Birth: New York City, NY
Name of Person: John Doe
Age at Death: 75 years
Cause of Death: Natural Causes
Place of Death: New York City, NY
Date of Death: 10/10/1975
Signature: _____
Title: _____
Printed Name: _____
Signature: _____
Title: _____
Printed Name: _____

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02195

2211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville		c. LENGTH OF STAY IN 1b 2½ years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville		d. STREET ADDRESS 3316 Lorin Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3316 Lorin Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William		First	Middle Richard	Last Edwards	4. DATE OF DEATH February 14	Month February	Day 14	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/22	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordnance Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Yard		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Richard Edwards Sr.				14. MOTHER'S MAIDEN NAME Mattie Shields				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11		17. INFORMANT Marion Edwards, same as # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED February 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/17/59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Suitland, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Henklein Sons</i>	ADDRESS 1756 Penna. Ave., N.W.	24a. REC'D BY REGISTRAR FEB 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					
VS. A15ME SM 2/57								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2212

CERTIFICATE OF DEATH

Reg. Dist. No. 02196

1. PLACE OF DEATH a. COUNTY <i>Prince Geo.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Prince Geo. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale md.</i>		c. LENGTH OF STAY IN 1b <i>8 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt, md. 23</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial - 4408 Greensbury</i>		d. STREET ADDRESS <i>10 B Laurel Hill Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>K Marion Higgins</i>	First <i>H</i>	Middle <i>Virginia</i>	Last <i>Higgins</i>	4. DATE OF DEATH Month <i>2</i>	Day <i>16</i>	Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>11-26-1898</i>	9. AGE (In years last birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby Sitter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Mr. Luther M. Slacum</i>		14. MOTHER'S MAIDEN NAME <i>May Va. Florence</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>220-12-6023</i>		17. INFORMANT <i>Hospital Records - 4408 Greensbury Rd. Rockville</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral hemorrhage & Arteriosclerosis undetermined</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		DUE TO <i>(c)</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 16, 1959</i> to <i>Feb 16, 1959</i> , that I last saw the deceased alive on <i>Feb 16, 1959</i> , and that death occurred at <i>750 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Riverdale, Md.</i>					
ACTUAL SIGNATURE <i>L W Malin</i>		DATE SIGNED <i>2-16-59</i>					
PHYSICIAN'S NAME (Type) <i>L W Malin M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/20, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Belair Memorial Gardens</i>		22d. LOCATION (City, town, or county) <i>Belair</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Rd</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 19 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kaus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

CERTIFICATE OF DEATH

Date _____

Name _____

Cause _____

Name _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2184

CERTIFICATE OF DEATH

Reg. Dist. No.

12197

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3809--31st Street				d. STREET ADDRESS 3809--31st Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHANNA	Middle CONRAD	Last ESLEY	4. DATE OF DEATH February 24th,	Month 1959	Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4th, 1870	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Eppers				14. MOTHER'S MAIDEN NAME Betty (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>(If yes, give year or date of service)</small>		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alba Donaldson, 3809--31st St. Mt. Rainier, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1						INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Decubitus Ulcers, hip & back---2 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, NOTIFY MEDICAL EXAMINER)</small>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1950, to <u>Feb. 24th</u> , 1959, that I last saw the deceased alive on <u>Feb. 23rd</u> , 1959, and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Herbert G. Brandes</i>		M.D.		400-W--Street, N.E. Washington, D.C.		DATE SIGNED Feb. 24th, 1959	
PHYSICIAN'S NAME (Type) Herbert G. Brandes							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27th, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 27 1959		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG239 3-2-59 et

2175

CERTIFICATE OF DEATH

Reg. Dist. No.

02198

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Washington		b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 327 E. Capitol St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Feb. 22 1959	
3. NAME OF DECEASED (Type or print) Thomas Dudley Farrah		First	Middle	Last	Month	Day	Year
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-78	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 80	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Farran		14. MOTHER'S MAIDEN NAME Martha Herbert		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-14-9311		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) Generalized arterio - sclerosis		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1, 1958 to Feb. 22, 1959 , that I last saw the deceased alive on Feb. 21, 1959 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Frances Farran		ADDRESS (Street, city or town, state) 25 N.Y. Ave NW, 22359		DATE SIGNED 2/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		22d. LOCATION (City, town, or county) WASH. D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Stanlon		ADDRESS 3831 Ga Ave NW		24a. REC'D BY REGISTRAR DATE 2-22-59		24b. REGISTRAR'S SIGNATURE Arthur S. Thriss	
FEB 25 '59							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. ATSM
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i> 30 days c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i> 14 d. STREET ADDRESS <i>5000-Hollywood Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary P. Fletcher</i>		First <i>Mary</i> Middle <i>P.</i> Last <i>Fletcher</i>	4. DATE OF DEATH Month <i>Feb.</i> Day <i>9th</i> Year <i>1959</i>
5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>2/1/1876</i>		9. AGE (In years from birth to) <i>83</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> own home		11. BIRTHPLACE (State or foreign country) <i>unknown</i>	
13. FATHER'S NAME <i>William Sinclair</i>		14. MOTHER'S MAIDEN NAME <i>unknown Jones</i> adopted by <i>Hos. and Susan Fletcher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>not</i>		16. SOCIAL SECURITY NO. <i>3727-35-0000</i> 17. INFORMANT <i>Clyde D. Fletcher</i> Addressee <i>3727-35 st. Mt. Rainier, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Pulmonary congestion & edema</i> Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerotic heart disease</i> (c) <i>due to</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? <i>Intertrochanteric fracture of right femur</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fall in home</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> 7.30 1-10- 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>College Park - P. G. - Md</i> (County) <i>Prince Georges</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED <i>2-9-59.</i>	
EXAMINER'S NAME (Type) <i>JOHN T. MALONEY, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
220. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/11/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Bladensburg Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home</i>		ADDRESS <i>Mt. Rainier Md.</i> 240. REC'D BY REGISTRAR <i>FEB 11 '59</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Calvin L. Lewis</i>	

EXHIBIT C
EXAMINER'S COPY



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear of I. C. E. Club		e. STREET ADDRESS # 5 Larches Court		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Leon Fones		First	Middle	Lost	4. DATE OF DEATH Month February 28	Day	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 13, 1900	9. AGE (In years last birth 58 yrs.)	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Fones				14. MOTHER'S MAIDEN NAME Mae I. Boyd Travis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW L		17. INFORMANT Mrs Florence Valitine		3321 Highwood Drive S.E. Washington 20, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 977 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severance of arteries of both wrists							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cut wrists with a knife or blade			
20c. TIME OF INJURY Hour 2/28/59		Month, Day, Year 1959	20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Place of death	20f. (City or town) Morningside	(County) P. G.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				DATE SIGNED			
EXAMINER'S NAME (Type) James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-1959	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Washington Nat'l	22d. LOCATION (City, town, or county) Suitland, Md			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald A. Mattingly</i>				24a. REC'D BY REGISTRAR 131-1188			
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Traas</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2176 CERTIFICATE OF DEATH

Reg. Dist. No. 02201

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b July 3, 1958		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,		d. STREET ADDRESS 14709 Carrollton Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Michael Full		First S.	Middle GALLAGHER	Last	4. DATE OF DEATH Feb. 8	Month	Day	Year	
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 30, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Michael Full		14. MOTHER'S MAIDEN NAME Anna Price		Address Mrs. Mary G. Grady, 14709 Carrollton Rd., Rockville					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary G. Grady, 14709 Carrollton Rd., Rockville		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 21 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that I attended the deceased from Dec 21 , 1958, to Feb 8 , 1959, that I last saw the deceased alive on Feb 7 , 1959, and that death occurred at 6 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas F. Collins M.D. 339 H St NE DATE SIGNED 2-8-59			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md.		ADDRESS Raymond A. Ziska	24a. REC'D BY REGISTRAR FEB 10 '59	24b. REGISTRAR'S SIGNATURE Robert L. Trahan					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—CERTIFICATE OF DEATH

8158

DECEASED PERSON'S NAME John Doe	SEX Male	AGE 65 years	CAUSE OF DEATH Cancer
ADDRESS 123 Main Street	STREET NUMBER 123	CITY Baltimore	STATE Maryland
NAME AND ADDRESS OF DOCTOR Dr. John Smith, 456 Main Street	NAME AND ADDRESS OF FUNERAL DIRECTOR Funeral Home, 567 Main Street	DATE OF DEATH 05/05/2023	TIME OF DEATH 10:00 AM
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
Signature: John Doe			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02202

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>USAF Hospital Andrews</i>		c. LENGTH OF STAY IN lb <i>RURAL</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF Hospital Andrews</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Timothy Wayne GEODES</i>		d. STREET ADDRESS <i>Bryans Rd. Trailer Pk, Lot # 31.</i>	
4. DATE OF DEATH <i>Feb 4 1959</i>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cau</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 11, 1951</i>	
9. AGE (In years lost birthday) <i>8 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>New Orleans, La</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George C. Geddes</i>		14. MOTHER'S MAIDEN NAME <i>Alice Brickey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Mrs Alice Brickey Daley (M)</i>		Address <i>Bryans Rd. Trailer Pk, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>053.4</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cardiac Arrest</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Overwhelming Septicemia</i>		(c) DUE TO <i>6 HR Nomin</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4 Feb 1959</i> to <i>4 Feb 1959</i> , that I last saw the deceased alive on <i>4 Feb 1959</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Vincent P. Ringrose Jr. M.D.</i> USAF Hospital Andrews DATE SIGNED <i>4 February 1959</i>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <i>Vincent P. Ringrose Jr Capt USAF (MC) Andrews AFB, Maryland</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL FEB. 6, 1959</i>	
22b. DATE THEREOF <i>FEB. 6, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NATIONAL</i>	
22d. LOCATION (City, town, or county) <i>ARLINGTON, Va.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldi Funeral Home</i>		24a. REC'D BY REGISTRAR DATE <i>FEB. 6 '59</i>	
ADDRESS <i>816 H St. N.E., Washington, D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner notified and approved.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02203

1		2171		CERTIFICATE OF DEATH	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in before being filed with the registrar.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.			
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9000 51st avenue		e. STREET ADDRESS 14 College Park, Md.			
3. NAME OF DECEASED First Albert Middle E. Last Gilbert		4. DATE OF DEATH Month Feb Day 14, Year 1959			
5. SEX male white		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov 2, 1864		9. AGE (In years last birthday) 94 yrs.	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Canada	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs L H Hill 9223 Longbranch Parkway Address Silver Spring, Md	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 hr.	
332X		Cerebral hemorrhage		b. Arteriosclerosis - Hypertension 30 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Carcinoma of Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____	
alive on _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____	
ACTUAL SIGNATURE R.D.BAKER M.D.		ADDRESS (Street, city or town, state) M.D. 2513 Brooklawn Rd. ADDRESS (Street, city or town, state) Philadelphia, Pa. DATE SIGNED 2/14/59		21. I certify that I attended the deceased from _____	
PHYSICIAN'S NAME (Type) R.D. BAKER M.D.		22c. NAME OF CEMETERY OR CREMATORIAL M. Pleasant Cemetery		22d. LOCATION (City, town, or county) Geneva, Ohio (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 2/16/59		22b. DATE THEREOF 2/16/59		24a. REC'D BY REGISTRAR DATE FEB 17 '59	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Catharine S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2255

CERTIFICATE OF DEATH

Reg. Dist. No.

02204

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
PRINCE GEORGES MARYLAND		D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
GLENN DALE (RURAL)		1 yr 7 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
(GLENN DALE HOSPITAL)		WASHINGTON 47 x 3	
3. NAME OF DECEASED (Type or print)		First	Middle
WILBERT		W.	GRISSEY
4. DATE OF DEATH		Month	Day Year
FEB.			i 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
MALE		WHITE	9/26/14
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) yrs.	
PAINTER		44	
10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
—		NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		BALLIE H. GRISSEY	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
SALLIE H. DAVIS		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		237-22-0978 DECEDED	
Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY TUBERCULOSIS	
002X		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. } (b)		DUE TO	
{		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PULMONARY EMPHYSEMA 1 yr 7 mos.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		Glenn Dale Hospital 2/1/59	
PHYSICIAN'S NAME (Type)		M.D. (Glenn Dale, Md.)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		1/159	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
		Bensalem, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
W.W. Chambers & Sons		24a. REC'D BY REGISTRAR	
		DATE FEB 4 '59	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2214 CERTIFICATE OF DEATH

Reg. Dist. No.

02205

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION Prince General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
3. NAME OF DECEASED (Type or print) Clarence First E. Middle HAGEN (Hagen)		4. DATE OF DEATH Feb. 4 Month Day Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Biochemist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Plant Industry	
10c. BIRTHPLACE (State or foreign country) Lake Park, Minn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence E. Hagen		14. MOTHER'S MAIDEN NAME Irene Charlotte Ebeltoft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 502-10-5222	
17. INFORMANT Colleen M. Hagen, 11500 Cedar Lane, Beltsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial dysfunction Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 4, 1959, to Feb. 4, 1959, that I last saw the deceased alive on Feb. 4, 1959, and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr Albert Roth		ADDRESS (Street, city or town, state) Riverdale DATE SIGNED 2-8-59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9th, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
		24b. REGISTRAR'S SIGNATURE Albert L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

~~REF ID: A6592~~

~~REF ID: A6592~~

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2256

CERTIFICATE OF DEATH

Reg. Dist. No.

02206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5610 Ruatan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle BENNETT	Last HALEY		
4. DATE OF DEATH	February 12th, 1959	Month Day Year			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Dots Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Kent Store, Virginia	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary E. Haley, 5610 Ruatan St. Berwyn Hgts., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH 3 h	
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <i>Hypertension of cerebral arteries</i>		.5 years	
(c) <i>Hypertension cerebral vascular disease</i>				.5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
Hour a. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21. I certify that I attended the deceased from <i>001 1st</i> , 19 <i>57</i> , to <i>Feb. 12th</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-7</i> , 19 <i>57</i> , and that death occurred at <i>41501</i> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE	<i>Till Bergemann</i>		M.D.	ADDRESS (Street, city or town, state)	DATE SIGNED
PHYSICIAN'S NAME (Type)	<i>Till BERGEMANN, M.D.</i>		<i>4314 GALLATIN ST.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 16th, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Pr. Geo. Co., Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.	ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 17 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

81-2000748-01 JAM 90 THE MICHIGAN STATE CIRCUIT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2257

CERTIFICATE OF DEATH

Reg. Dist. No.

02207

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Mass. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AF Base		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF Hospital Andrews		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 20, D.C. S.E. 58X-3	
3. NAME OF DECEASED (Type or print) First Eric Middle David Lost Harding		4. DATE OF DEATH Month February Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 15 February 1959
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) — yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard D. Harding		14. MOTHER'S MAIDEN NAME Mother-Thelma Madeleine Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT		1066 Barnaby Terr. SE Father-Richard D. Harding Washington 20, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Cardio-vascular-pulmonary collapse	
DUE TO Prematurity		7 days	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 February, 1959, to 22 February, 1959, that I last saw the deceased alive on 22 February, 1959, and that death occurred at 1215 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE John A. Moore M.D.		USAF HOSPITAL ANDREWS, AAFB, 25 DC 22FEB59	
PHYSICIAN'S NAME (Type) JOHN A. MOORE CAPT USAF (MC)		USAF HOSPITAL ANDREWS, AAFB, 25 DC 22FEB59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF FEB. 25, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home 816 H St. N.E., WASH. D.C.		ADDRESS DATE FEB 26 '59	
		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE C. H. R. L.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

二

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2258

CERTIFICATE OF DEATH

Reg. Dist. No.

02208

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland		b. by COUNTY 1 Prince George's Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indianhead		d. STREET ADDRESS 26J Riverview Village			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		d. STREET ADDRESS 26J Riverview Village				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Adam	Middle David	Last Heffelfinger	4. DATE OF DEATH February	Month 25	Day 1959	Year	
5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 15 October 1918	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Adam David Heffelfinger		14. MOTHER'S MAIDEN NAME Verna Dorothy Leber							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Official Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Acute Myelogenous Leukemia DUE TO (c)		Massive intracranial hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 4 Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Va.	(State) Va.
21. I certify that I attended the deceased from 25 February, 1959, to 25 February, 1959, that I last saw the deceased alive on 25 February, 1959, and that death occurred at 7:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE SANFORD L. BILLETT CAPT USAF (MC) M.D. USAF Hospital Andrews DATE SIGNED 25 Feb 59									
PHYSICIAN'S NAME (Type)		SANFORD L. BILLETT CAPT USAF (MC)				Andrews AFB, Wash 25, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MARCH 2, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Arlington NATIONAL		22d. LOCATION (City, town, or county) Arlington Va		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		ADDRESS 816 H St. N.E., Wash.		24a. REC'D BY REGISTRAR DATE MAR 27 '59		24b. REGISTRAR'S SIGNATURE John S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Date of death	
John Doe		July 1, 1950	
Age at death		Cause of death	
65 years		Natural death	
Place of death		Name of physician	
Home		Dr. John Doe	
Name and address of informant		Signature of physician	
John Doe, 123 Main Street, Los Angeles, California		John Doe, M.D.	
Relationship to deceased		Signature of informant	
Son		John Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2215

CERTIFICATE OF DEATH

Reg. Dist. No.

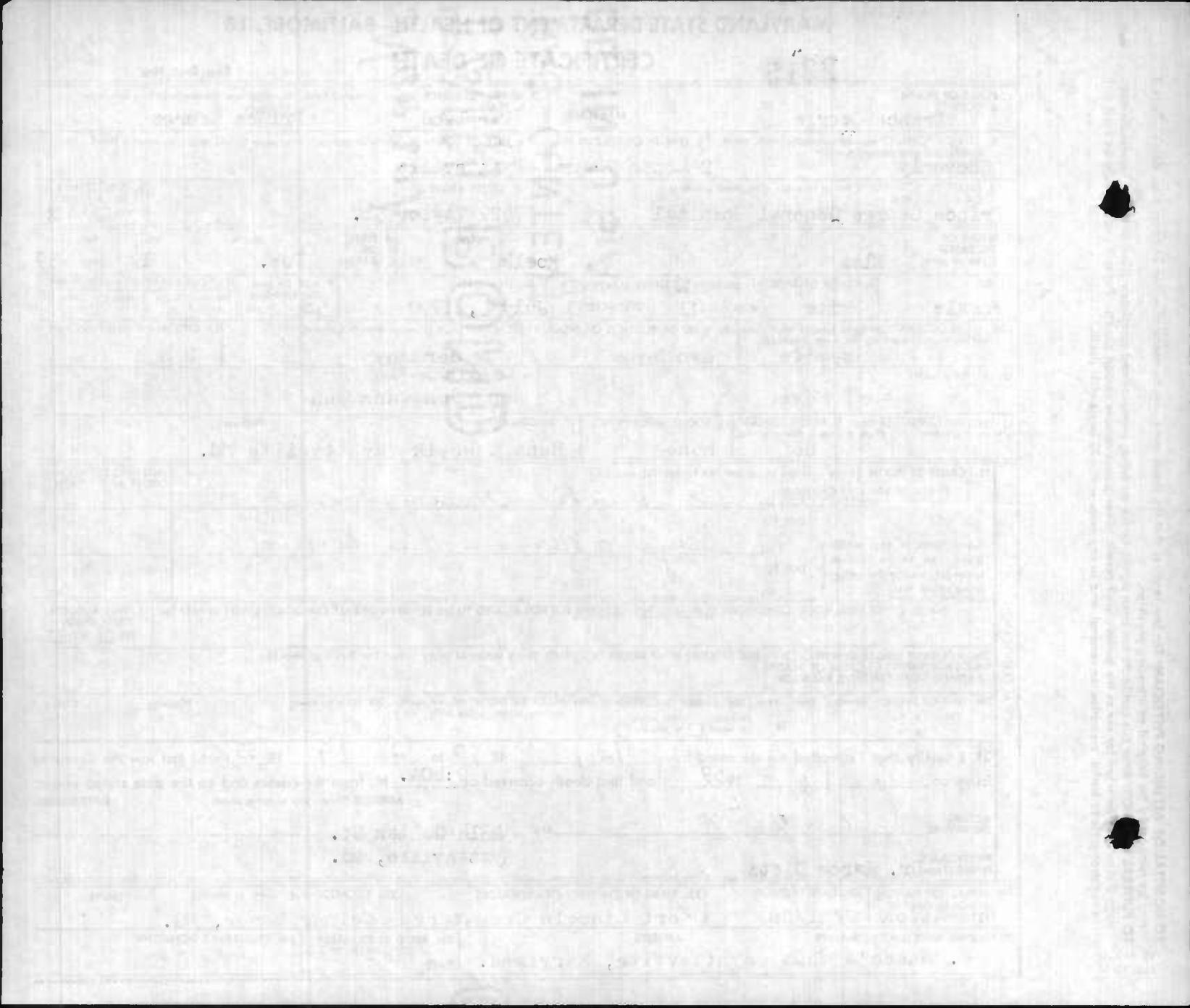
02209

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		COUNTRY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Month 9Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 7422 Taylor St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elsa	Middle Hoelk	Last 	4. DATE OF DEATH Feb. 19 1959	Month Feb.	Day 19	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 5, 1900	9. AGE (in years last birthday) 58	IF UNDER 1 YEAR Months 58	IF UNDER 24 HRS Days 58	Hours 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Karl Meyer		14. MOTHER'S MAIDEN NAME Anna Schawanemann					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Hans C Hoelk Hyattsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO DUE TO (c)		<i>Sarcophaga esculenta</i> <i>Chrysogaster hebetana</i>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 59 , to 2-19 , 19 59 , that I last saw the deceased alive on 2-18 , 19 59 , and that death occurred at 9:40A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Aaron Dietz</i>						ADDRESS (Street, city or town, state) 4314 Gallan St. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/21/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

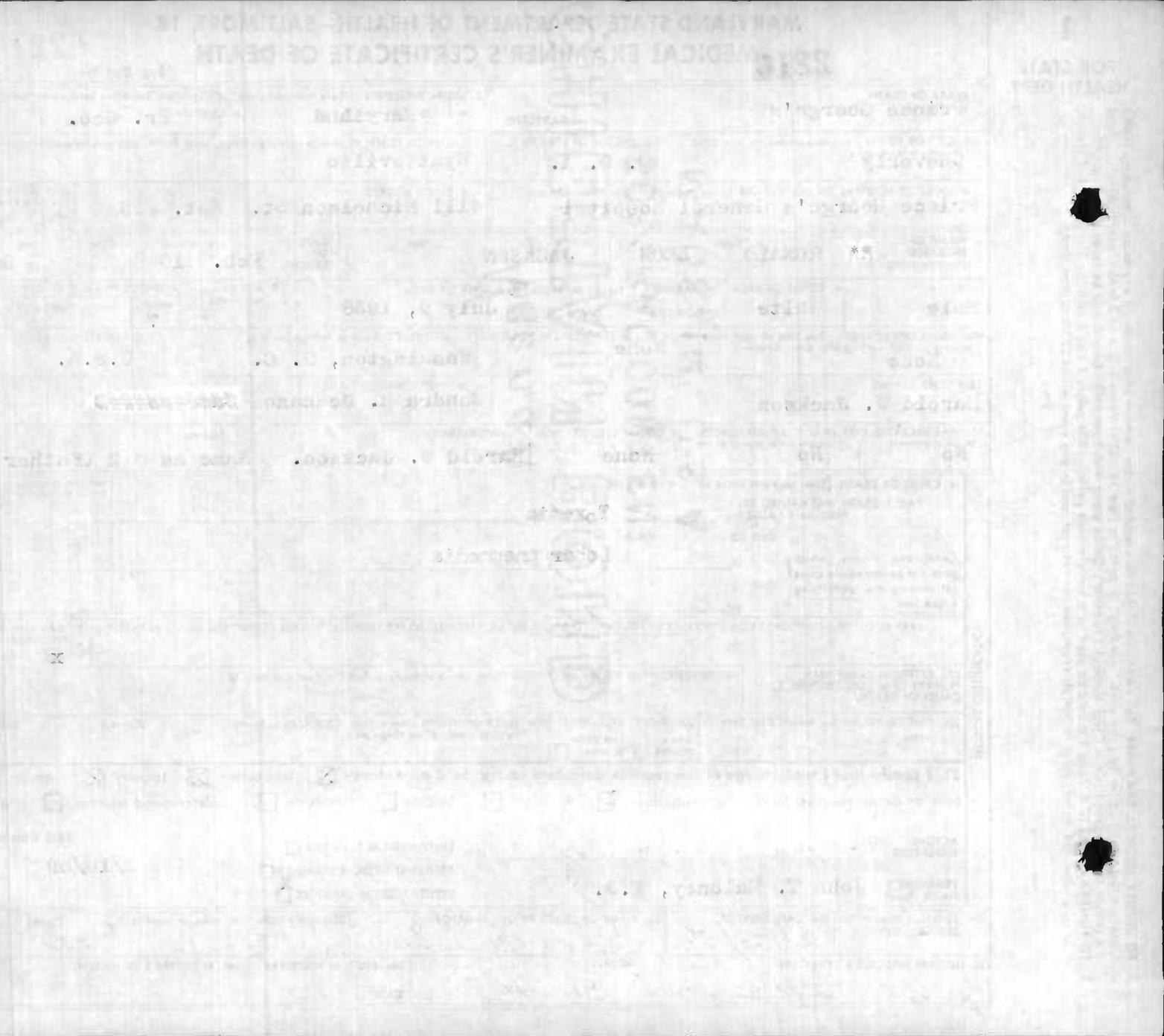
VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

42210

Reg. Dist. No.

1. PLACE OF DEATH Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 4111 Nicholson St. Apt. # 5	
3. NAME OF DECEASED (Type or print) RONALD		First LEON	Middle JACKSON
Last		4. DATE OF DEATH Feb. 10	Month Month
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 9, 1958		9. AGE (In years from birthday) yrs. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold W. Jackson		14. MOTHER'S MAIDEN NAME Sandra H. DeShazo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harold W. Jackson.		Address Same as # 2 (Father)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 490X DUE TO Toxemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Lobar pneumonia (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED 2/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2/12/59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem
22d. LOCATION (City, town, or county) Seftland		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee & Sons Co 300-4th & N.E.		ADDRESS 9411 Nicholson St. Apt. # 5	24a. REC'D BY REGISTRAR FEB 13 '59
		24b. REGISTRAR'S SIGNATURE Albert L. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2217 CERTIFICATE OF DEATH

102211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 38 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Richard	Middle Raymond	Last Jacoby
4. DATE OF DEATH Feb 10 1959	Month Day Year	Month Day Year	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1902
9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Uniontown Pa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Robert Jacoby	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. no	17. INFORMANT Lillian Jacoby	Address Bowie, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0			
DUE TO Coronary Occlusion with acute myocardial infarction few hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterosclerotic heart Disease few years			
DUE TO (c) Generalized Arterosclerosis years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/20 1958 to 2/10 1959 , that I last saw the deceased alive on 2/9 1959 , and that death occurred at 355 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		ADDRESS (Street, city or town, state) R.F.D. Bowie Md. 20705	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 10/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/59	
22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF DELAWARE
DEPARTMENT OF STATE

CEMETERY OF DEATH

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02212

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE				
<i>Prince George</i> <i>6411 S. Cedar Heights</i> <i>MARYLAND</i>		<i>Maryland</i> <i>b. County Prince George</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<i>Cedar Heights</i>		<i>3 1/2 years</i> <i>Cedar Heights</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
<i>6411 S. Cedar Heights</i>		<i>6411 S. Cedar Heights</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First	Middle			
<i>Flora</i>		<i>Howard</i>	<i>Johnson</i>			
4. DATE OF DEATH	Month	Day	Year			
<i>Feb. 16, 1874</i>	<i>2</i>	<i>6</i>	<i>1959</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH			
<i>Male</i>	<i>Negro</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>Feb. 16, 1874</i>			
9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.			
<i>84 yrs.</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY				
<i>None</i>		<i>None</i>				
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
<i>Maryland</i>		<i>U.S.A.</i>				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
<i>John Edward Johnson</i>		<i>Unknown?</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.				
<i>No</i>		<i>No</i>				
17. INFORMANT		Address				
<i>Daughter (Blady Johnson) 6411 S. St.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO <i>434.1</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO						
(c)						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Mt. Zion, Md.</i>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>John G. Todd</i>		DATE SIGNED				
EXAMINER'S NAME (Type) <i>John G. Todd M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (SIXTY)		22b. DATE THEREOF <i>2/9/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oak Grove</i>		22d. LOCATION (City, town, or county) <i>Mt. Zion, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Saunderson</i>		ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

THE STATE GOVERNMENT OF MEGHNAJARNADESH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2218 CERTIFICATE OF DEATH

02213

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 28 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights		d. STREET ADDRESS 733 61 St. Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Jefferson		First	Middle	Last	4. DATE OF DEATH February 2 19 59	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/70	9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR 89 yrs.	IF UNDER 24 HRS. Months 89 yrs.	Days 89 yrs.	Hours 89 yrs.	Min. 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farman for doctors, D.C. G.V. Emp.		10b. KIND OF BUSINESS OR INDUSTRY Clouds Va		11. BIRTHPLACE (State or foreign country) Clouds Va		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Willy Johnson		14. MOTHER'S MAIDEN NAME Polly Johnson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Jefferson Jr.		Address 5812 L st. Fairmont Hgts.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. H. F.		DUE TO 177x							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		A. S. H. D Ca of prostate with generalised metastasis							
DUE TO (c)		8-12 weeks 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clouds Va		20f. (City or town) Clouds Va		(County) Clouds Va	(State) Clouds Va
21. I certify that I attended the deceased from 1. 31. 59 , to 2. 2. 59 , that I last saw the deceased alive on February 2, 19 59 , and that death occurred at 12:58A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clouds Va							
ACTUAL SIGNATURE William D. Rosson, M.D.		DATE SIGNED Feb 11 1959							
PHYSICIAN'S NAME (Type) William D. Rosson, M.D.		- 5304 Annapolis Rd., Bladensburg, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Rural		22b. DATE THEREOF 2/2/59		22c. NAME OF CEMETERY OR CREMATORIAL Clouds Va		22d. LOCATION (City, town, or county) Clouds Va		(State) Clouds Va	
23. FUNERAL DIRECTOR'S SIGNATURE Alma J. funeral home of a funeral		ADDRESS 800 Weller St. Alexandria, Va.		24a. REC'D BY REGISTRAR FER 11 1959		24b. REGISTRAR'S SIGNATURE Clouds Va			

STATE OF HAWAII
CERTIFICATE OF DEATH

Dr. Howard Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2219

CERTIFICATE OF DEATH

Reg. Dist. No.

02214

1 D M 08 I		2219		CERTIFICATE OF DEATH				
1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 15 days						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3						
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last	4. DATE OF DEATH Feb. 19	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/68	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - Railroad		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. lost		17. INFORMANT Decedent		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO		PULMONARY TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 8 mos				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). PULMONARY FIBROSIS + EMPHYSEMA; CEREBRAL ARTERIOSCLEROSIS								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital, Glenn Dale, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/59		22c. NAME OF CEMETERY OR CREMATORIAL Glenn Dale Cemetery		22d. LOCATION (City, town, or county) Washington D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Barbara J. Weiss		ADDRESS 485 N. W.E.D.		24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thrua		

STATE OF MARYLAND - DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG239 3-9-59 et

2177

CERTIFICATE OF DEATH

Reg. Dist. No.

02215

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>MARYLAND</u>				
<u>PRINCE GEORGES MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> 85X3				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 yrs +</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>149 B21/4A SANNEI ROAD</u>				
3. NAME OF DECEASED (Type or print) <u>Agnes Josephine Kean</u>		First <u>Agnes</u>	Middle <u>Josephine</u>			
3. NAME OF DECEASED (Type or print) <u>Agnes Josephine Kean</u>		Last <u>Kean</u>	4. DATE OF DEATH <u>Feb. 24</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
		8. DATE OF BIRTH <u>Nov. 12, 1870</u>				
9. AGE (In years last birthday) <u>88 yrs.</u>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>				
11. BIRTHPLACE (State or foreign country) <u>Charlestown, West Virginia U.S.</u>		Months <u>88</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>						
13. FATHER'S NAME <u>Maurice Kean</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fox</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>				
17. INFORMANT <u>Home RECORDS</u>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & arteriosclerosis heart disease</u> { DUE TO DUE TO (c)		1 week				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pielmonary</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>falling down</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3066 Queen St., NW, Wash. DC</u>	20f. (City or town) <u>3066 Queen St., NW, Wash. DC</u>	(County) <u>D.C.</u>	(State) <u>D.C.</u>
21. I certify that I attended the deceased from <u>April 10</u> , 19 <u>58</u> , to <u>Feb. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 23</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. Stuart Lyddane</u>		ADDRESS (Street, city or town, state) <u>3066 Queen St., NW, Wash. DC</u>		DATE SIGNED		
PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>2-26-59</u> 22c. NAME OF CEMETERY OR CREMATORIY <u>ST. PETERS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOLIVAR HEIGHTS HARPER'S FERRY, W.V.A.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Donnell 2224-Wis. Ave. Washington 7 DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

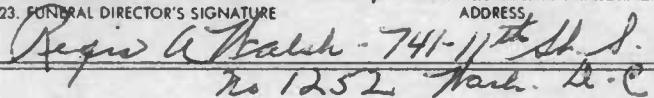
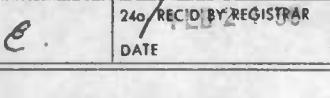
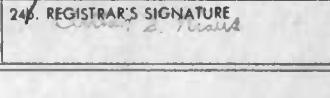
Hannigan

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G240 3-19-59 et
2260 CERTIFICATE OF DEATH

Reg. Dist. No.

12216

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN lb 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2423 Minnesota Ave S E		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, Andrews AFB						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Frederick	Middle NMI	Last KNOPF	4. DATE OF DEATH February	Month 20	Day 19	Year 59
5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 October 1893	9. AGE (In years last birthday) 109 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Glazer		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frederick Knopf				14. MOTHER'S MAIDEN NAME Emily Muth				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 578-01-7444		17. INFORMANT Jack B Knopf		Address 2423 Minnesota Ave Wash D. C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Arteriosclerotic heart disease with congestive failure				7 Days		
(c) Pulmonary emphysema								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 14 February, 1959, to 20 February, 1959, that I last saw the deceased alive on 20 February, 1959, and that death occurred at 8:20 AM, from the causes and on the date stated above. ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) HEINO TREES						ADDRESS (Street, city or town, state) Andrews AFB, Washington 25 D C		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-59		22c. NAME OF CEMETERY OR CREMATORIUM Arl. Neck Cemetery		22d. LOCATION (City, town, or county) Arlington, Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE  Regis A. Walsh - 741-17th St. S. E. No 1252 Park. D.C.		ADDRESS		24a. REC'D BY REGISTRAR 		24b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2220

CERTIFICATE OF DEATH

Reg. Dist. No.

12217

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glendale									
c. LENGTH OF STAY IN lb 25 Days				d. STREET ADDRESS Box 374									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Louis	Middle W	Last Kutsch	4. DATE OF DEATH Feb. 12 1959	Month Feb.	Day 12	Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1899	9. AGE (In years last birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Tax assement			11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Harry Kutsch				14. MOTHER'S MAIDEN NAME Amelia Crozier				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-03-9125	17. INFORMANT Wilmer Louis Kutsch, Son	Address Ardmore .Md Landover, Box 280
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rh. pul. embolus 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myo cardiac infar. left (c) Art. sclerosis th. de.													
INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville Md.					
20f. (City or town) Hyattsville				(County) M.D.				(State) Md.					
21. I certify that I attended the deceased from 1-10 1940 , to 2-12 1959 , that I last saw the deceased alive on Feb. 12 1959 , and that death occurred at 2:55 AM , from the causes and on the date stated above.													
ACTUAL SIGNATURE C. Deitz ADDRESS (Street, city or town, state) Hugo Hallerel 2128 DATE SIGNED 2/12/59													
PHYSICIAN'S NAME (Type) A Deitz				22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/14/59				22d. LOCATION (City, town, or county) Colmar Manor, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE FEB 16 '59					
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

VS A15 (4)
15M 10/57

BY INFORMATION RECEIVED FROM THE STATE OF CALIFORNIA
CERTIFICATE OF EXISTENCE

RECEIVED
IN THE STATE OF CALIFORNIA
AT THE CITY OF SACRAMENTO

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02218

1. PLACE OF DEATH a. COUNTY	Prince George		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	a. STATE Maryland		b. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Forestville		2 mo	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Forestville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Cherry Lane			d. STREET ADDRESS	d. STREET ADDRESS		Cherry Lane
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Michael		Wendell	Lewis	Feb	17	1959	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY?
Male	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec 5, 1958	2	13			U. S. A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
none		Maryland

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Vincent Lewis	Jean Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
W			Jean Lewis, same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
493X Pneumonia		
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)
DUE TO		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
			19			

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
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ACTUAL SIGNATURE <i>James J. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>Feb 17, 1959</i>		
EXAMINER'S NAME (Type) <i>James J. Boyd</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL/CREMATION REMOVAL (Specify)	22b. DATE THEREOF <i>2-20-59</i>	22c. NAME OF CEMETERY OR CREMATORIALY <i>Arling Star</i>	22d. LOCATION (City, town, or county) <i>St. Myer Va</i>	(State)

23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry J. Washington</i>	ADDRESS <i>467 N st N.W.</i>	24a. REC'D BY REGISTRAR <i>Arthur S. Evans</i>	24b. REGISTRAR'S SIGNATURE
		DATE <i>FEB 20 '59</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2221

CERTIFICATE OF DEATH

Reg. Dist. No.

02210

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 5714 J. St. N.E., Washington, D.C.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle A.	Last Linkins	4. DATE OF DEATH Feb.	Month 9	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/4/91	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail Worker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Linkins		14. MOTHER'S MAIDEN NAME Norma Simmons					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Dolly L. Prince, Sister, same Washington, D.C.		Address 1511 J N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) failure DUE TO (c) myocardial infarction.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 8, 1959, to Feb. 9, 1959, that I last saw the deceased alive on Feb. 9, 1959, and that death occurred at 4:15 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Charles C. Stageage		M.D. 3308 Perry St. Mt. Rainier, Md. 21092				DATE SIGNED 2/9/59	
PHYSICIAN'S NAME (Type)							
22b. BURIAL CREMATION, REMOVAL (Specify) 2-14-59		22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cemetery		22d. LOCATION (City, town, or county) D. C. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews		ADDRESS 3619-14st NW		24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2222

CERTIFICATE OF DEATH

Reg. Dist. No. 02220

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 4109 34th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) George		First F.	Middle . Little	Last Little	4. DATE OF DEATH Feb. 12 1959	Month Feb.	Day 12	Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-4-1876	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard, Philadelphia, Pa.		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Isaac Little		14. MOTHER'S MAIDEN NAME Amy Hall										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Paul E. Wright		Address above						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO (b) DUE TO (c) DUE TO (d)		Pulmonary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1952 , to 2/12 , 19 59 , that I last saw the deceased alive on 2/12 , 19 59 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Leon Gallen						ADDRESS (Street, city or town, state) 7208 Collewill Rd.		DATE SIGNED W. H. Heath Jr. Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 1959		22c. NAME OF CEMETERY-OR CREMATORIAL Congressional Cemetery		22d. LOCATION (City, town, or county) Washington D.C.						
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR PEB 18 59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause						

STATE OF GEORGIA
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2262

CERTIFICATE OF DEATH

Reg. Dist. No.

02226

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ammendale		c. LENGTH OF STAY IN lb 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ammendale					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammendale Normal Institute				d. STREET ADDRESS Ammendale Normal Institute		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Brother Galbert Lucian (Patrick McGurk)		First	Middle	Last	4. DATE OF DEATH February 4th,	Month	Day	Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20th, 1879		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Christian Brother		10b. KIND OF BUSINESS OR INDUSTRY Religious Order		11. BIRTHPLACE (State or foreign country) Derry County, Ireland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hugh McGurk		14. MOTHER'S MAIDEN NAME Latitia McGee							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Records--Ammendale Normal Institute		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Uremia				INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Arthritis		Arteriosclerotic C-V-R disease 20 yrs Gen. Arterosclerosis 20 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Laurel		(County)	(State)
21. I certify that I attended the deceased from 9/15/52 to 2/14/59 , that I last saw the deceased alive on 12/3/58 , and that death occurred at Laurel , M., from the causes and on the date stated above. ACTUAL SIGNATURE J. M. Warren		M.D.		ADDRESS (Street, city or town, state) Laurel					
DATE SIGNED 2/14/59									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6th, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Private Cemetery		22d. LOCATION (City, town, or county) Ammendale Normal Institute		(State) Beltsville P.O. Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

前言第1章—第10章 | 基础知识与实践案例

**FOR STATE
HEALTH DEPT.**

DEPUTY MEDICAL EXAMINEE: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHM. Page 5 may be retained by your files.

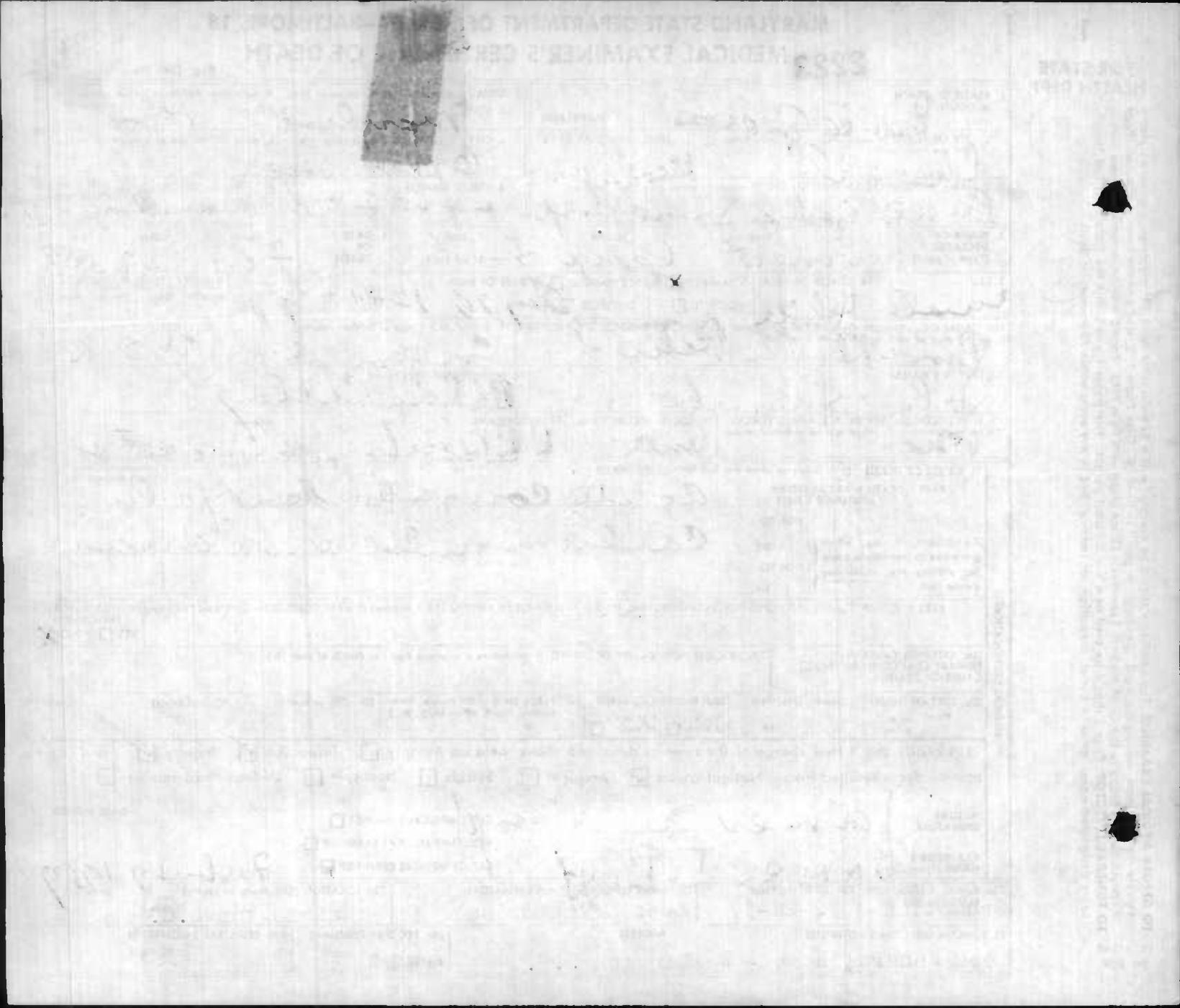
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince George Chesapeake Neck Maryland		a. STATE Maryland b. COUNTY PG	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cremation		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X Open Heed	
Prudential George Funeral Home		STREET ADDRESS 14425 South Pennsylvania	
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ernest George Lumb		4. DATE OF DEATH Feb 27 1959	
First Middle Last		Month Day Year	
5. SEX Male White		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Day 20 1881	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lumb		14. MOTHER'S MAIDEN NAME Ellen Colley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Acute congestive heart failure Cardiovascular renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE James J. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-28-59	
22c. NAME OF CEMETERY OR CREMATORIUM Lees Crematorium		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		ADDRESS	
24a. REC'D BY REGISTRAR MAR 2 '59		24b. REGISTRAR'S SIGNATURE Oliver S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02222

2224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook Md		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9437 Washington Ave.				d. STREET ADDRESS 9437 Washington ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Olga Middle Emma Matilda Last May		4. DATE OF DEATH Month February Day 11, Year 1959					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1889	9. AGE (in years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Berlin Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Henry R May Kensington Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X DUE TO Cerebral vascular accident (Thrombosis) since starting Oct 1958							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis years (c) generalized Atherosclerosis years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia							
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21, 1959, to 2/11, 1959, that I last saw the deceased alive on 2/10, 1959, and that death occurred at 10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Signature: James Kurtz M.D. Date Signed: 2/11/59 ACTUAL SIGNATURE: H. James Kurtz PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transtil permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Date of Death

Age at Death

Name of Hospital

Name of Doctor

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Coroner

Name of Sheriff

Name of Probate Court

Name of Attorney

Name of Clerk

Name of Sheriff's Office

Name of Probate Court

Name of Attorney

Name of Clerk

Name of Sheriff's Office

Name of Probate Court

Name of Attorney

Name of Clerk

Name of Sheriff's Office

Name of Probate Court

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2225

CERTIFICATE OF DEATH

Reg. Dist. No.

n2223

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		b. COUNTY Prince George's	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS Lanham Severn Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James S Mc Bride		First James	Middle S
4. DATE OF DEATH Month Feb		Day 15	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 21, 1914
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years by birthday) 44 yrs.	10. IF UNDER 1 YEAR Months 0
11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY Southern Oxygen Co	11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME James Smith Mc Bride		14. MOTHER'S MAIDEN NAME Irene Cottrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577 12 9464	17. INFORMANT Address Hospital record Cheverly Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebro-Sclerotic Heart Disease (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale DATE SIGNED 215 57			
ACTUAL SIGNATURE Albert Roth		PHYSICIAN'S NAME (Type) Albert Roth	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	24a. REC'D BY REGISTRAR DATE FEB 19 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - GALVANOGRA

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. FISHER	60	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
101 W. 12TH ST.	APT. 2B	NEW YORK	NY
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME	NAME OF CEMETERY
DR. RICHARDSON	HOSPITAL	WILLIAMS	WOODSIDE
RELATIONSHIP	DEATH CERTIFICATE NUMBER	DATE ISSUED	EXPIRATION DATE
SPOUSE	100-12345678	APRIL 1, 1968	JULY 1, 1968
PRINT NAME	STAMP	STAMP	STAMP
EDWARD J. FISHER			

18

FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12224

Reg. Dist. No.

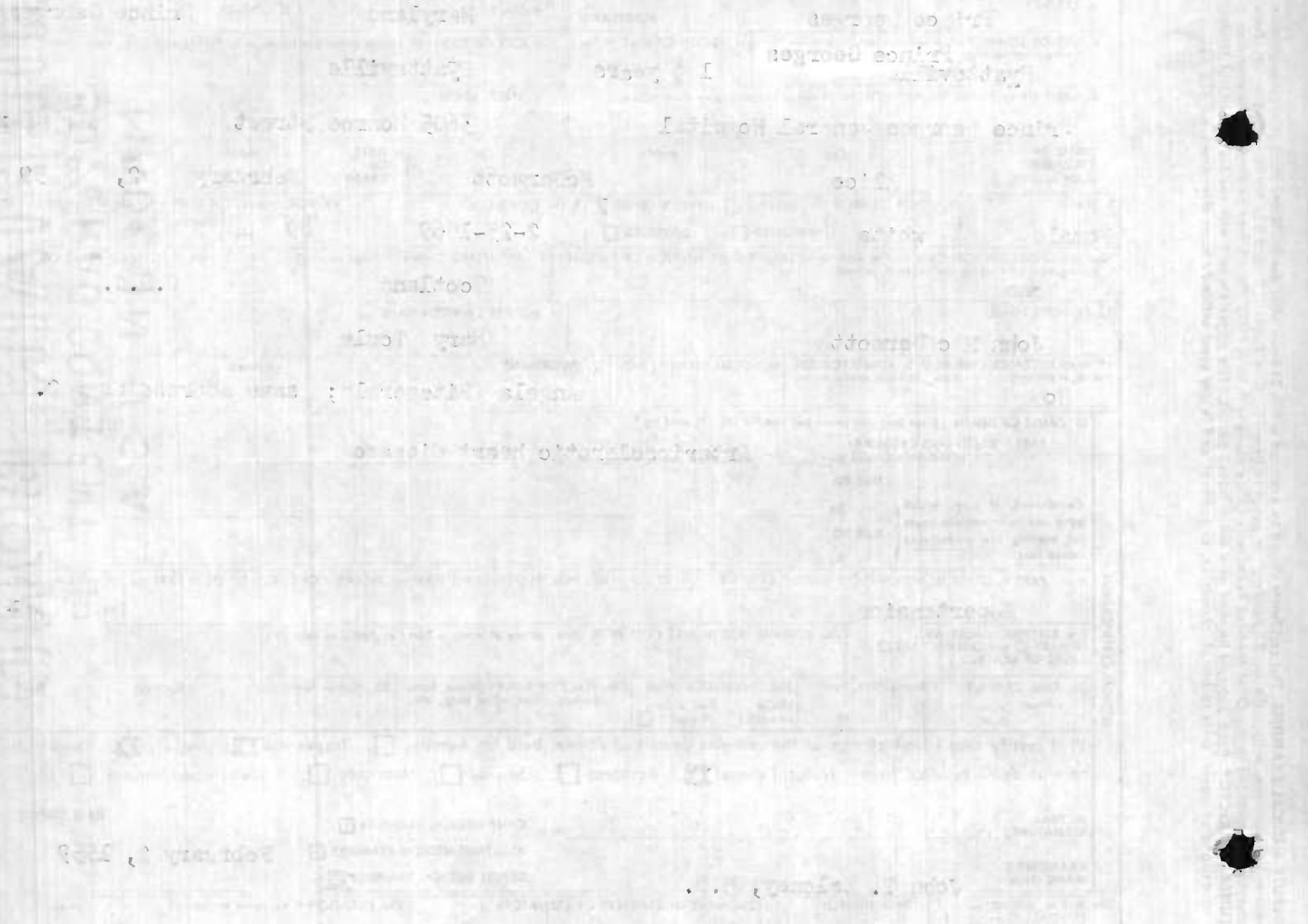
2178

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 1 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5605 Monroe Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alice	Middle McDermott	Last February 2, 1959	4. DATE OF DEATH	Month February	Doy 2	Year 1959
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-25-1869	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months 89	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M c Dermott				14. MOTHER'S MAIDEN NAME Mary Toule			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Angela Fitzgerald; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (o), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED February 2, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.	22d. BURIAL, Cremation, Removal (Specify) Burial 2-4-1959 in Oliver Wash DC						
22b. DATE THEREOF 2-4-1959	22c. NAME OF CEMETERY OR CREMATORIAL Oliver		22d. LOCATION (City, town, or county) Wash DC				
23. FUNERAL DIRECTOR'S SIGNATURE Gerald Mattingly	ADDRESS 131-1/2 S. St. Feb 4 '59		24a. REC'D BY REGISTRAR Arthur L. Thorne		24b. REGISTRAR'S SIGNATURE Arthur L. Thorne		
V.S. A15ME BM 2/57							



Medical Examiners

Office



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2226

CERTIFICATE OF DEATH

Reg. Dist. No.

02225

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. STREET ADDRESS 15515 Nicholson St.		f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ruby		First	Middle	Lost	4. DATE OF DEATH Feb. 15	Month	Day	Year 59
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 16, 1890	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William Fees			14. MOTHER'S MAIDEN NAME Isabel Sheets					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT David A Mc Gibbon		Address Melbourne Florida.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO (1) BACTERIAL PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (2) DIABETIC NEURITIS DUE TO (c) (3) DIABETES MELLITUS								
INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days 20 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct. 1953 to Feb. 15, 1959 that I last saw the deceased alive on 2/14/59 , and that death occurred at 8:35A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Debbie Roth M.D. ADDRESS (Street, city or town, state) Annapolis Road, Lanham, Md. DATE SIGNED								
PHYSICIAN'S NAME (Type) Dr. Albert Roth								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 18, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.								
24a. REC'D BY REGISTRAR DATE Feb. 17, 1959								
24b. REGISTRAR'S SIGNATURE Arthur S. Trahan								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BY DEDICATION—MUCH TO THE SATISFACTION OF

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2227

CERTIFICATE OF DEATH

Reg. Dist. No.

02227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS Box 412 Route #1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Benjamin P. McKnew		First	Middle	Lost	4. DATE OF DEATH February 24, 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1876	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dredge Inspector		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Benjamin P. McKnew			14. MOTHER'S MAIDEN NAME Dena Aitcheson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Benjamin P. McKnew		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 177X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) due to (c) <i>Bronchopneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH 1 week.					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Carcinoma prostate.</i>			1 year					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pyelonephritis</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Laurel Md	
21. I certify that I attended the deceased from 4/18, 1958, to 2/24, 1959, that I last saw the deceased alive on 2/24/59, 1959, and that death occurred at 4:15 PM, from the causes and on the date stated above. ACTUAL SIGNATURE J. M. Warren M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) J. M. WARREN Laurel Md DATE SIGNED 2/25/59			21. I certify that I attended the deceased from 4/18, 1958, to 2/24, 1959, that I last saw the deceased alive on 2/24/59, 1959, and that death occurred at 4:15 PM, from the causes and on the date stated above. ACTUAL SIGNATURE J. M. Warren M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) J. M. WARREN Laurel Md DATE SIGNED 2/25/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/26/59		22c. NAME OF CEMETERY, OR CREMATORIAL Fair Haven Cemetery		22d. LOCATION (City, town, or county) Calmar Manor, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Red at Sanderson, Laurel, Md		ADDRESS		24a. REC'D. BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE DATE MAR 2 '59		

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02228

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillcrest Heights</i>		b. COUNTY <i>Prince George</i>	
c. LENGTH OF STAY IN 1b <i>8 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Hillcrest Heights</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2300 Jameson Street</i>		d. STREET ADDRESS <i>2300 Jameson Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James Dwight McLaughlin</i>		First <i>J</i>	Middle <i>Dwight</i>
4. DATE OF DEATH <i>Feb 19 1959</i>		Month <i>Feb</i>	Day <i>19</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 21 1888</i>		9. AGE (In years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>coffee manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Iowa</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph John McLaughlin</i>	
14. MOTHER'S MAIDEN NAME <i>Ella Maye</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> Address <i>4809-Aetr St. S.E.</i>	
16. SOCIAL SECURITY NO. <i>136-12-1234</i>		17. INFORMANT <i>Joseph J. McLaughlin, Bachelor of Arts</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>Acute congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cardiovascular renal disease</i> (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James T. Boyd</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>James T. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/21/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons Co</i>		ADDRESS <i>300-4th st N.E. Wash 2 D.C.</i>	24a. REC'D BY REGISTRAR <i>Date Feb 20 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>Caroline S. Johnson</i>	

STATE OF

100 MIA

MANUFACTURED BY
MEDICAL EXAMINER'S OFFICE

100 MIA

18
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by the funeral director. Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Maryland c. LENGTH OF STAY IN 1b 5 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Hyattsville Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4112 Queensbury Road				d. STREET ADDRESS 4112 Queensbury Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Oscar		First	Middle	Lost	4. DATE OF DEATH	Month Feb	Doy 2, Year 19 59-
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool and Die maker		10b. KIND OF BUSINESS OR INDUSTRY Gischner Iron Works		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME August Messerschmidt				14. MOTHER'S MAIDEN NAME Clara Hesse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Liddy Messerschmidt		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute congestive heart failure INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED February 2, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.	22b. DATE THEREOF Feb 6, 1959	22c. NAME OF CEMETERY OR CREMATORIUM George Washington	22d. LOCATION (City, town, or county) Hyattsville, Md.	(State)			
22e. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	24a. REC'D BY REGISTRAR F. Gasch's Sons	24b. REGISTRAR'S SIGNATURE Catherine S. Kraus					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Md.	DATE FEB 6 '59					

EXPLORATION OF THE CULTURE-GENE INTERACTION IN CYPRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2264 CERTIFICATE OF DEATH

Reg. Dist. No. **02230**

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Ritchie		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL---Ritchie					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7700 Whitehouse Rd., S.E.				d. STREET ADDRESS 7700 Whitehouse Rd., S.E.					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Maude A. Moore		First	Middle	Last	4. DATE OF DEATH Feb. 20, 1959.	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1905	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Tenant Home	11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Albert Windsor				14. MOTHER'S MAIDEN NAME Mary Windsor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Leonard Moore---same as above		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carcinoma of Rectum with metastases DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) none of note									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes							
20c. TIME OF INJURY Hour o. m. 19 p. m.		Month, Day, Year Feb 16, 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5440 Silver Hill Rd.	20f. (City or town) Forestville	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from Feb 16, 1957 , to Feb 20, 1959 , that I last saw the deceased alive on Feb 20, 1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Paul L. Van Natta M.D. ADDRESS (Street, city or town, state) 5440 Silver Hill Rd. Forestville, Md. DATE SIGNED 2/20/59									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/59	22c. NAME OF CEMETERY OR CREMATORIUM Epiphany Cemetery		22d. LOCATION (City, town, or county) Forestville, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Upper Marlboro, Md.				ADDRESS	24a. REC'D BY REGISTRAR FEB 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

07 JUN 2010 - 071005Z TO THE TRASO STATE QUALITY

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Morningside 522 Maple Road S.E.		
3. NAME OF DECEASED (Type or print) Charles		First Middle Last Murray	4. DATE OF DEATH Month February Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.	17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				
Acute congestive heart failure Cardiovascular renal disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 27, 1959	
EXAMINER'S NAME (Type) James I. Boyd	22b. DATE THEREOF 2-27-59		22c. NAME OF CEMETERY OR CREMATORIAL K. J. Med. School	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR MAR 3 '59	24b. REGISTRAR'S SIGNATURE <i>Robert L. Finch</i>

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2229 CERTIFICATE OF DEATH

02232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN lb adm. 6-14-58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - City 3801-4	
3. NAME OF DECEASED (Type or print) MAUDE		d. STREET ADDRESS 509 Ormaney Rd.	
First		Middle Lest	
4. DATE OF DEATH Feb. 6 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-7-1879	
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10. PERSONAL OCCUPATION (Give kind of work done during working life, even if retired) Business Woman		11. KIND OF BUSINESS OR INDUSTRY Public Relations	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert G Newbegin		14. MOTHER'S MAIDEN NAME Mary V. Van Dillen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 324-56-0918	
17. INFORMANT Hospital Records, Laurel SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malignant neoplasm of cervix DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? Dementia due to cerebral arteriosclerosis (334) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-14-58 to 2-6-59, that I last saw the deceased alive on 2-6-59, and that death occurred at 2:47 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE LINON P. KRAMER M.D.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM 2-6-59	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/6/59	
22c. NAME OF CEMETERY OR CREMATORIAL Green wood Cem.		22d. LOCATION (City, town, or county) Brooklyn, N.Y. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Schlesinger & Sons - Baltimore		24a. REC'D BY REGISTRAR FEB 9 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

61 BROOKDALE HIGH SCHOOL STATE GRANT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2230

CERTIFICATE OF DEATH

Reg. Dist. No.

02233

1. PLACE OF DEATH a. COUNTY Prince Georges County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Hr 22 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		First Boy	Middle Notarberardino
4. DATE OF DEATH Month February	Day 11	Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/59
9. AGE (In years lost birthday) yrs. 0	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 22	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gerardo Richard Notarberardino		14. MOTHER'S MAIDEN NAME Marcia Ann O'Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 17. INFORMANT Marcia A. Notarberardino, Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0		Address Laurel Manor Ct. Laurel Md.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH (Pulmonary Alveolar Hemorrhage)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 11 59 , 1959, to FEB 11 59 , 1959, that I last saw the deceased alive on FEB 11 59 , 1959, and that death occurred at 8:16 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 402 Main St Laurel Md	
ACTUAL SIGNATURE John Buell		DATE SIGNED 2/17/59	
PHYSICIAN'S NAME (Type) D. John Buell			
22a. BURIAL, CREMATION, BURIAL (Specify) CREMATION		22b. DATE THEREOF 2-17-59	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS 2077191XV6	
24a. REC'D BY REGISTRAR FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arnold S. Krause	

STATE OF NEW YORK - CAPITAL DISTRICT

CERTIFICATE OF DESIGN

663

RECEIVED
JULY 1 1968



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2231

CERTIFICATE OF DEATH

Reg. Dist. No.

02234

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 35 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 5905 Forest Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Constantine Francis		First	Middle	Last	4. DATE OF DEATH February 11	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10/8/87	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Gov't Printing Office		11. BIRTHPLACE (State or foreign country) St. Paul, Minn.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Andrew Novicke (Nowicki)				14. MOTHER'S MAIDEN NAME Anna Ross				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gordon A. Novicke, 5804 Dewey St., Cheverly, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)								
<i>L. Cor. art occlam.</i> INTERVAL BETWEEN ONSET AND DEATH <i>Arteros & clauder HT de.</i> 5 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diss. LUPUS ERITHMATOSIS RHEUMATOID ARTHRITIS CA of VAGINAL BLADDER ULCERATIVE COLITIS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 1954 , 19, to 11 Feb , 19 57 , that I last saw the deceased alive on 11 Feb , 19 57 , and that death occurred at 10:55PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave., Cheverly, Md. DATE SIGNED 2/12/1959								
ACTUAL SIGNATURE <i>John Kehoe</i>		PHYSICIAN'S NAME (Type) John Kehoe						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14th, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Traas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN STATE BANK OF HENRY - VOLUME 18

CERTIFICATE OF DEATH

1832

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2232

CERTIFICATE OF DEATH

Reg. Dist. No.

112235

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		15 d. STREET ADDRESS Hyattsville, 7215 Colesville, Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Francis	Last Orlando
4. DATE OF DEATH	Month Feb.	Day 8	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/03
9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 0	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician--Foreman		10b. KIND OF BUSINESS OR INDUSTRY Heavy Construction	
10c. BIRTHPLACE (State or foreign country) Washington, D.C.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Orlando		14. MOTHER'S MAIDEN NAME Amelia Kingini	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 578-09-4707	
17. INFORMANT Mrs. Marion E. Orlando, 7215 Colesville Road		Address Hyattsville P.O. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
<i>Pulmonary Edema</i> <i>Cardiac Decompensation</i> <i>Pulmonary Thrombosis</i>			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/27 , 19 58 to 2/15 , 19 59 , that I last saw the deceased alive on 2/7 , 19 59 , and that death occurred at 10:20 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Gallin		ADDRESS (Street, city or town, state) 7205 Columbia Rd. At Hyattsville 2/10/59	
PHYSICIAN'S NAME (Type) Leonard Gallin M.D.		DATE SIGNED Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11th, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Prince George's Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS 24a. REG'D BY REGISTRAR FEB 10 1959	
		DATE Arthur S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2233

CERTIFICATE OF DEATH

Reg. Dist. No.

03467

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 Hrs 15 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 3200 Kenilworth Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Baby	Middle Girl	Last Pleasants	4. DATE OF DEATH 2 21 1959	Month 2	Day 21	Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-59	9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. DAYS 15	Hours 2	Min. 15
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Newborn	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Walter Clement Pleasant	14. MOTHER'S MAIDEN NAME Gay Atkinson	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 Hrs, 15 min
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from 2/21/59 to 2/21/59 , that I last saw the deceased alive on 2/21/59 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
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ACTUAL SIGNATURE C. C. Hageage	ADDRESS (Street, city or town, state) M.D. 3308 Ferry St. Mt. Rainier, Md. 20772	DATE SIGNED 2/21/59
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22a. BURIAL / CREMATION / REMOVAL (Specify) Cremation	22b. DATE THEREOF 3/2/59	22c. NAME OF CEMETERY OR CREMATORIUM Prince George's General Hospital, Cheverly, Md.	22d. LOCATION (City, town, or county) (State)
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23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.	ADDRESS Administrator	24a. REC'D BY REGISTRAR MAR 11 '59	24b. REGISTRAR'S SIGNATURE Colleen L. Keenan
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CONFIDENTIAL - SUBJECT TO THE TRAVEL STATE CHARTER

STATE OF CALIFORNIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2185

CERTIFICATE OF DEATH

Reg. Dist. No.

02230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Montgomery PRINCE GEORGES, MARYLAND		N.H. PRINCE GEORGES CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
TAKOMA PARK		TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
7218 MINTER PLACE,	7218 MINTER PLACE		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	RAL	E.	POWERS
4. DATE OF DEATH	Month	Day	Year
	FEB.	17	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG 14, 1909
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
49 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
INSURANCE AGT		PRUDENTIAL INS CO	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TUCKER County, W. Va.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
ZACHARIAH JACOB POWERS		LILLIE E. COSNER.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
		Mrs. LILLIE E. POWERS, 7218 MINTER PLACE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		sudden	
420.1 DUE TO		Acute Coronary Thrombosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		14 days	
{ (b) DUE TO		Coronary Artery disease	
{ (c) DUE TO		Atrio - pulmonary and hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		12/28, 1957, to 2-17, 1959, that I last saw the deceased alive on _____	
alive on 2/13, 1959, and that death occurred at 6:15 A.M.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)		FRANCIS X. RICHARDSON M.D. 7717 ALASKA AVE. NW. WASHINGTON DC	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		FEB 19, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Geo. WASHINGTON CEMETERY		REGINA MATTISON, MATTISON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
J. Arthur Walters, 254 Carroll St NW, DC		24a. REC'D BY REGISTRAR	
		DATE FEB 18 '59	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Thorpe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2234

CERTIFICATE OF DEATH

Reg. Dist. No.

02237

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Basil	Middle	Last Queen	4. DATE OF DEATH	Month 2 Day 22 Year 1897
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 27 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Race Ass.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Queen Sr.		14. MOTHER'S MAIDEN NAME Mary Ellen Queen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Queen, Brother, Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Nephrotic Syndrome		INTERVAL BETWEEN ONSET AND DEATH	
		Generalized Arteriosclerosis			
		Hypertensive Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE D. Slagayreus M.D. ADDRESS (Street, city or town, state) 6311 Bowie Ave. Riverdale Md. DATE SIGNED 2/23/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORIUM 38th & Bodily Island Ave. Wash. D.C. N.W.	
22d. LOCATION (City, town, or county) Bowie (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Frazee's Funeral Home		24a. REC'D BY REGISTRAR FEB 25 '59		24b. REGISTRAR'S SIGNATURE Clayton	

81 PINEHORN - DEPARTMENT OF STATE - WASH DC

DEPARTMENT OF STATE

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

by the hospital or attending physician.
CTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with
detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2265 CERTIFICATE OF DEATH

Reg. Dist. No. 02238

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Dale (rural)		c. LENGTH OF STAY IN 1b RURAL and give nearest town 1 yr., 9 mos. and 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Laura	Middle V.	Last Ramseur
4. DATE OF DEATH	Month 2	Day 15	Year 19 59
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/67
9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months - Days -	11. IF UNDER 24 HRS. Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Monroe Clark	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Mrs. Cleo M. Fowler	Address Granddaughter
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 002X Pulmonary tuberculosis; urinary tract infection, chronic, multiple organisms.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) multiple organisms.	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/8/1957 , to 2/15/1959 , that I last saw the deceased alive on 2/15/1959 , and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Moe Weiss M.D. DATE SIGNED 2/15/59			
ACTUAL SIGNATURE Moe Weiss	PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		
22a. BURIAL OR CREMATION REMOVAL (Specify) 2-17-59	22b. DATE THEREOF 2-17-59	22c. NAME OF CEMETERY OR CREMATORIUM UNION WASH. D.C.	22d. LOCATION (City, town or county) UNION WASH. D.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. W. GYNES, Jas. A. Mahoney 116 Mass Ave, N.Y.	ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

RECORDED IN THE STATE OF
IDAHO TO STACIRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2235

CERTIFICATE OF DEATH

Reg. Dist. No.

02239

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 7001 Walker Mill Road. S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Rosa C. Richardson		First	Middle	Last	4. DATE OF DEATH February 25 1959	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/73	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 1		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Samuel Hayes		14. MOTHER'S MAIDEN NAME Whittemore							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Clarence Farrell		Address 6997 Walker Mill Rd., Dist Hyatt Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		caused by Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 mo.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6124 Central Ave		20f. (City or town) Glenelg		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from Jan 15 , 1957, to Feb. 25 , 1959, that I last saw the deceased alive on February 25, 1959 , and that death occurred at 9:23 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124 Central Ave									
ACTUAL SIGNATURE William Brainin		DATE SIGNED 2/25/59							
PHYSICIAN'S NAME (Type) W.M. BRAININ		22c. NAME OF CEMETERY OR CREMATORIAL Epiphany		22d. LOCATION (City, town, or county) Glenelg, Maryland		(State) Md.			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 2-28-59		24a. REC'D BY REGISTRAR W.W. Chambers Co., Inc.		24b. REGISTRAR'S SIGNATURE John J. Hause			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Inc., Washington, D.C.		ADDRESS Washington, D.C.		DATE Feb 27 '59					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - DEPARTMENT OF STATE - CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2180

CERTIFICATE OF DEATH

Reg. Dist. No. 02240

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. LENGTH OF STAY IN lb 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6514 Medwick Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Austin Theodore Rollins Middle		4. DATE OF DEATH Month Feb 5, 1959 Day Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1873
9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer	
11. KIND OF BUSINESS OR INDUSTRY Produce		12. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Alburtion B Rollins		14. MOTHER'S MAIDEN NAME Sidney Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mary Ernest		Address West Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/24, 1959, to 2/5, 1959, that I last saw the deceased alive on 2/5, 1959, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest A. Sorenson		ADDRESS (Street, city or town, state) 7006 New Hampshire Ave M.D.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 2/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/59	
22c. NAME OF CEMETERY OR CREMATOR Y Shilow Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Shilow Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR FEB 9 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Koenig	
VS A15 (4) 15M 10/57		DATE FEB 9 '59	

STATE OF TEXAS



15
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

92241

Reg. Dist. No.

2236

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 8251 River View Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Wise	Last Ruefly	4. DATE OF DEATH February 1	Month February	Doy 1	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1905	9. AGE (In years last birthday 53 yrs.)	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oren Ruefly				14. MOTHER'S MAIDEN NAME Lucille Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT 901 Owens Road S.E. Benjamin Ruefly Oxon Hill, Md.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **581.0** DUE TO **Hemorrhage and shock**

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost. (b) **Gastric Hemorrhage, acute gastritis**
DUE TO
(c) **Cirrhosis of the liver**

INTERVAL BETWEEN
ONSET AND DEATH

2 MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
of work of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type) **James I. Boyd**

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

February 1, 1959

22a. BURIAL, Cremation, Removal (Specify)

22b. DATE THEREOF **Feb 3 - 59**

22c. NAME OF CEMETERY OR CREMATORIUM **Cedar Hill Cemetery**

22d. LOCATION (City, Town, or County) **Brentwood**

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS **Summers Brothers 1661-9d Hope Rd**

24a. REC'D BY REGISTRAR

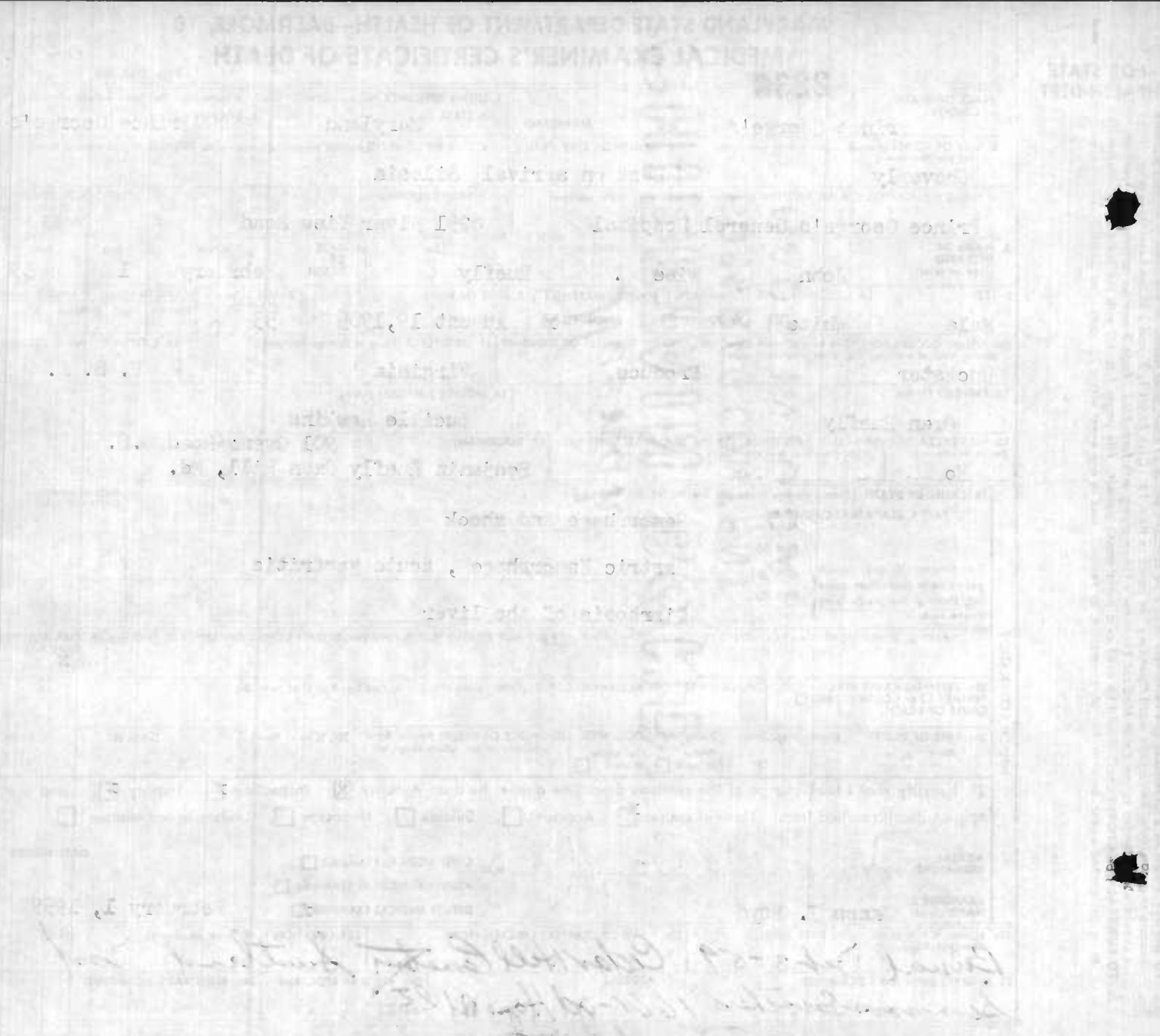
DATE **FEB 4 '59**

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2266 Film G258 2-18-59 et 02240

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Holabird</i>		c. LENGTH OF STAY IN lb <i>7 wks.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairview French Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Pauline</i>		First <i>Pauline</i>	Middle <i>Olga</i>
		Last <i>Hageage</i>	4. DATE OF DEATH Month <i>Feb.</i> Day <i>12</i> Year <i>1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Dec. 25, 1875</i>
8. AGE (In years last birthday) <i>83 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>
13. FATHER'S NAME <i>Charles Gatten Kieno</i>		14. MOTHER'S MAIDEN NAME <i>Pauline Cooke</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Nursing Home Records</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		Cerebral Hemorrhage <i>1 hr.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Hypertensive Arteriosclerosis <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 21, 1958</i> , to <i>Feb. 12, 1959</i> , that I last saw the deceased alive on <i>Feb. 12, 1959</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P. C. Hageage</i>		ADDRESS (Street, city or town, state) <i>M. 3308 Perry St. Mt. Rainier, Md.</i>	
PHYSICIAN'S NAME (Type) <i>C. C. Hageage M.D.</i>		DATE SIGNED <i>2/12/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/16/1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Bethelwood Cemetery</i>
22d. LOCATION (City, town or county) <i>Colman Heights Rd. Gaithersburg, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co - Riverton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Oliver S. Kraus</i>

CERTIFICATE OF DEATH

BOOK

~~1~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02243

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File Pages 1 and 2 with the State Health Department, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Health Department, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr.Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 55 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4309 Farragut Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
f. STREET ADDRESS 4309 Farragut Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First Severe	Middle Last
4. DATE OF DEATH February 18 1959		Month	Day Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Engineer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Severe		14. MOTHER'S MAIDEN NAME Charlotte Elizabeth Shipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Martha Severe; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of the liver 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 19, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/21/59	22c. NAME OF CEMETERY OR Crematory George Washington	22d. LOCATION (City, town, or county) Hyattsville (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	24a. REC'D BY REGISTRAR DATE FEB 24 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Krause	

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
MEDICAL EXAMINER'S OFFICE

STATE OF

RECEIVED
MAY 10 1968
SACRAMENTO POLICE DEPARTMENT
SACRAMENTO, CALIFORNIA

SEARCHED INDEXED SERIALIZED FILED
MAY 10 1968
SACRAMENTO POLICE DEPARTMENT
SACRAMENTO, CALIFORNIA

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MAY 10 1968
SACRAMENTO POLICE DEPARTMENT
SACRAMENTO, CALIFORNIA

SEARCHED INDEXED SERIALIZED FILED
MAY 10 1968
SACRAMENTO POLICE DEPARTMENT
SACRAMENTO, CALIFORNIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

90

O
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02244	
2267 CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.			15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eleven Cedars Nursing Home					d. STREET ADDRESS 6709 Queens Chapel Road,					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Dora	Middle Belle	Last Stack	4. DATE OF DEATH February 14, 1959		Month February	Day 14	Year 1959		
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1879		9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Wesley Lawrence					14. MOTHER'S MAIDEN NAME Irene Cox						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT N L Stack			Address Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cardio-vascular disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 4713-Berwyn Rd		(County) College Park	(State) Md.	
21. I certify that I attended the deceased from April 1958 to Feb 1959 , that I last saw the deceased alive on Feby 14 1959 , and that death occurred at 2 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) W.L. ETIENNE	DATE SIGNED 4/15/59
ACTUAL SIGNATURE W.L. ETIENNE		PHYSICIAN'S NAME (Type) W.L. ETIENNE									
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 2/15/59		22c. NAME OF CEMETERY OR CREMATORIUM Charlotte			22d. LOCATION (City, town, or county) North Carolina			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2182

Item 1 Film G239 3-2-59 et

Reg. Dist. No.

02245

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 2 weeks		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3304 Lancier Drive (At home)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
f. STREET ADDRESS 6714 Red Top Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nina Anne Stein		4. DATE OF DEATH Month February Doy 23 Year 1959	
5. SEX Female white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-30-59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Leo Stein		14. MOTHER'S MAIDEN NAME Anna Kate Jones Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Leo Stein; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 325.4 DUE TO Aspiration of food Conditions, if any, which gave rise to immediate cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mongoloid			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED February 22, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/59	
22c. NAME OF CEMETERY OR CREAMATORY St. Lincoln		22d. LOCATION (City, town or county) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche SONS Hyattsville Md		24a. REC'D BY REGISTRAR DATE FEB 25 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Collins S. Krause	

STATE NO.
1980

RECEIVED
MEDICAL RECORDS & CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02246

2237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. LENGTH OF STAY IN lb Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3525 Davis Street, N.W.	
3. NAME OF DECEASED (Type or print) James Montgomery Sullivan	First James	Middle Montgomery	Last Sullivan
3. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-11-39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. manager	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Sullivan	14. MOTHER'S MAIDEN NAME Virginia Saul		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 577-50-9970	17. INFORMANT Richard T. Sullivan, M.D. same address	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Severance of inferior vena cava, rupture of liver and spleen (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Operator of an automobile that went out of control and turned over.			
20c. TIME OF INJURY Hour 1.00 a.m. 2-19- 19 59	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Mt. Rainier, Pr. Geo. (County) Md. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 19, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.	220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	226. DATE THEREOF 2-21-59	22c. NAME OF CEMETERY OR CREMATORIUM CONGRESSIONAL CEM., WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol	ADDRESS 2224 - Wis. Ave. NW	24a. REC'D BY REGISTRAR FEB 24 '59	24b. REGISTRAR'S SIGNATURE Cathleen S. Koenig

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PN3. File pages 1 and 2 with the State Board of Health. To Funeral Director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1971-201

places have been visited

to purchase new material to construct

new buildings

X

and some additional money will be needed

for the construction of the new building.

It is recommended that the new building be built on the same site as the old one.

The new building should be larger than the old one.

The new building should be located in a more accessible area than the old one.

The new building should be located in a more accessible area than the old one.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02247

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jacquelin	Middle Elaine	Last Sweat
4. DATE OF DEATH	Month February	Day 23	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1958
9. AGE (In years last birthday) yrs. 4	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Vernon Earl Sweat		
14. MOTHER'S MAIDEN NAME Nancy Remos	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. none	17. INFORMANT Vernon E. Sweat, same as # 2	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) James I. Boyd	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		February 23, 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/59	22c. NAME OF CEMETERY OR Crematory Arlington National	22d. LOCATION (City, town, or county) Arlington Va (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR FEB 25 '59	24b. REGISTRAR'S SIGNATURE Albert S. Krause

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2268

CERTIFICATE OF DEATH

Reg. Dist. No. 02248

1. PLACE OF DEATH a. COUNTY <i>Pr. Geo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SUITLAND</i>		c. LENGTH OF STAY IN 1b <i>3 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5115-LOGAN ST. SE</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SUITLAND</i>	
d. STREET ADDRESS <i>5115 Logan St. SE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William J. Taylor		First	Middle
4. DATE OF DEATH Feb. 7 1959		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Mar. 16-1870		9. AGE (In years lost birthday) 88 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Taylor	
14. MOTHER'S MAIDEN NAME Jane' Porch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 331X	
16. SOCIAL SECURITY NO. 123-45-6789		17. INFORMANT William H. Taylor	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH One week	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) General Arteriosclerosis		DUE TO unknown	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) It induced cerebral hemorrhage. Duration unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Emporia (County) Virginia (State) VA	
21. I certify that I attended the deceased from July 1, 1957 to Feb. 7, 1959 , that I last saw the deceased alive on Feb. 7, 1959 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul C. Van Natta</i>		ADDRESS (Street, city or town, state) 5440 S. Columbia St. Emporia, VA	
PHYSICIAN'S NAME (Type) Paul C. Van Natta		DATE SIGNED 2/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-59	
22c. NAME OF CEMETERY OR CREMATORIAL Emporia Cemetery		22d. LOCATION (City, town, or county) Emporia, VA	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Seminars Bros. Funeral Home</i>		ADDRESS 1661-Good Hope Rd. SE Washington DC	
24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

MAGISTRAL STATE DEPARTMENT OF HEALTH - SANITATION 18

CERTIFICATE OF DEATH

258

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 112249

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE SANF	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE		c. LENGTH OF STAY IN 1b 78 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TENTH & MAPLE ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM HENRY THIRLES		First	Middle
		Last	4. DATE OF DEATH Feb 11 1959
5. SEX MALE		6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH MAR 10, 1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED RAILROAD CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY EIRKIDGE MD	11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME STEPHEN H THIRLES		14. MOTHER'S MAIDEN NAME SARAH WIRT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-8111	17. INFORMANT WIFE DAISY V THIRLES - SAME
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		cerebral hemorrhage	
(c)		generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CANCER OF RECTUM		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 402 MMN ST - LAUREL MD
21. I certify that I attended the deceased from FEB , 19 59 , to PRES , 19 59 , that I last saw the deceased alive on Feb 11 , 19 59 , and that death occurred at 245 M, from the causes and on the date stated above.		DATE SIGNED 2/11/59	
ACTUAL SIGNATURE J. R. O'Neill		M.D. 402 MMN ST - LAUREL MD	
PHYSICIAN'S NAME (Type) Drs McGehee & Buell		11 11	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/59	22c. NAME OF CEMETERY OR CREMATORIAL Trinity Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR Feb 16 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

81 STRONGLY-TO-EXTREMELY STATE OF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2270

CERTIFICATE OF DEATH

Reg. Dist. No.

112250

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTRY ENGLAND St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural T. B.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chaptico 18X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First Charles S.	Middle Thomas	4. DATE OF DEATH Month February Day 18 Year 1959
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 4, 1959	9. AGE (In years last birthday) yrs. Months 24 Days 14 Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Chaptico, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME George Aloysius Thomas	14. MOTHER'S MAIDEN NAME Mary Frances Young
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT George A. Thomas Chaptico, Maryland	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intra cranial Pressure</u> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Sub dural hematoma</u> DUE TO (c) <u>Birth</u>			INTERVAL BETWEEN ONSET AND DEATH unknown
			2 wks
			2 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Birth</u>		
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20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>18 Feb 59</u> , 19 <u>59</u> , to <u>18 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>18 Feb</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			ADDRESS (Street, city or town, state) Mechanicsville, Maryland
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ACTUAL SIGNATURE <u>DAVID L MOSSMAN</u>	M.D.	DATE SIGNED	
--	------	-------------	--

PHYSICIAN'S NAME (Type) DAVID L MOSSMAN	Mechanicsville, Maryland		
--	--------------------------	--	--

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's	22d. LOCATION (City, town, or county) (State) Morganza, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.	ADDRESS 1000214XV7	24a. REC'D BY REGISTRAR DATE 25 '59	24b. REGISTRAR'S SIGNATURE Curtis S. Kraus
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D 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02251

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

2239

1. PLACE OF DEATH
a. COUNTY

Prince George's MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George'

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

Dead on arrival

X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Seat Pleasant

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hosp.

d. STREET ADDRESS

6211 Field Street

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Doy

Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

9. AGE (In years
less birthday)
34 yrs.

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

Female

White

WIDOWED

DIVORCED

2/1/25

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas A. Moran

14. MOTHER'S MAIDEN NAME

Ruby Bunce

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
[Yes, no, or unknown]
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

James G. Todd

Address
Same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Coronary atherosclerosis

2 MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE MAR 5 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 film G240 3-18-59 et

02252

2240

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 56 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 816 Cobby Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Tompkins		First	Middle	Last	4. DATE OF DEATH February 26 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/06	9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 52 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Bronchopneumonia, left, c. abscess. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Spidemoid Ca b the esophagus. (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from December 31, 1958 , to February 26, 1959 , that I last saw the deceased alive on February 26, 1959 , and that death occurred at 8:35A M , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE David J. Clayman, 634 Beta Ave - Riverdale Md 20201								
PHYSICIAN'S NAME (Type)								
22a. BURIAL CREMATION, REMOVAL (Specify) 3-3-59		22b. DATE THEREOF 3-3-59		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn		22d. LOCATION (City, Igwn, or county) Washington, D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wistert Morgan		ADDRESS 1700 Vermont Ave N.W.		24a. REC'D BY REGISTRAR 498 DATE 2-27-59		24b. REGISTRAR'S SIGNATURE John H. Watson CONT'D. John H. Watson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OF ECONOMIC AND SOCIAL DEVELOPMENT OF KENYA

REPORT TO STATE COUNCIL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2271

CERTIFICATE OF DEATH

Reg. Dist. No.

02253

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills		c. LENGTH OF STAY IN 1b 17 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Landover Hills					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7105 - Varnum street		d. STREET ADDRESS 7105 - Varnum street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Walter Van Horn		First	Middle	Last	4. DATE OF DEATH Feb. 1st 1959	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1866	9. AGE (In years lost birthday) 92 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Seneca C. Van Horn		14. MOTHER'S MADDEN NAME Ann Catherine Lenkins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Adeline B. Roddy		Address as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) renal DUE TO chronic nephritis and arteriosclerosis (c)									
INTERVAL BETWEEN ONSET AND DEATH 3 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor		(County) Maryland	(State) Colmar Manor, Maryland
21. I certify that I attended the deceased from 1/27 , 1959 to 2/1 , 1959, that I last saw the deceased alive on 2/1 , 1959, and that death occurred at 8:35 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) George J. Hageage M.D. 3717-38th Ave									
ACTUAL SIGNATURE George J. Hageage									
DATE SIGNED 2/1/59									
PHYSICIAN'S NAME (Type) George J. Hageage		22b. DATE THEREOF 2/4/1959		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Maryland			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		24a. REC'D BY REGISTRAR DATE FEB 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan					
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS mt. Rainier, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use of the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2272 Item 7 Film G239 3-2-59 et
CERTIFICATE OF DEATH

82254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4304 Van Bruen St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Mc Naughton	Lost Vial	4. DATE OF DEATH	Month Feb	Day 24, Year 19 59-
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12 Aug 1889</i>	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Agriculture U of Md.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Vial				14. MOTHER'S MAIDEN NAME Carswells D Cragmire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W 1		17. INFORMANT Peter F. Vial Silver Springs, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> INTERVAL BETWEEN ONSET AND DEATH 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arterio - sclerosis heart disease</i> 2-3 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1959</i> to <i>Feb 1959</i> , that I last saw the deceased alive on <i>Feb 4, 59</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. Etienne</i> ADDRESS (Street, city or town, state) <i>4713 Berrywood Rd</i> DATE SIGNED <i>2/4/59</i> PHYSICIAN'S NAME (Type) <i>W. ETIENNE</i> M.D. <i>College Park, Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 2/26/59		22c. NAME OF CEMETERY OR CREMATORIALy Grange		22d. LOCATION (City, town, or county) (State) Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 25 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ALABAMA
DEPARTMENT OF PUBLIC SAFETY - DIVISION OF POLICE

CERTIFICATE OF DEATH

RECEIVED

REGISTRATION

SEARCHED

INDEXED

SERIALIZED

FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2273 CERTIFICATE OF DEATH

02255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
PRINCE GEORGES MARYLAND		Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
RURAL Washington DC	2 years	RURAL Washington DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS				
PRINCE GEORGES CO. REST HOME	16501 D'Arcy Rd - WDC 28				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
Louisa F			Washington		
4. DATE OF DEATH	Month	Day	Year		
	Feb	22	1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Female	U.S. Colored		7-2-1888	70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Domestic	Retired	Maryland	U.S.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			Address	
Robert Tugood	Anna Podson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT			
No	—	Blanche Bumbus NY NY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion				1 day
420.1	DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	General Arteriosclerosis			
	DUE TO				
	(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
none of note					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from June 1, 1958, to Feb 22, 1959, that I last saw the deceased alive on Feb 20, 1959, and that death occurred at 16501 D'Arcy Rd, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE	Dr. Paul C. Vanatta M.D. 5440 Silver Hill Rd SE				DATE SIGNED
PHYSICIAN'S NAME (Type)	Paul C. VAN ATTA WASHINGTON 28 DC				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)	
Burial	2-26-59	Brewer Hill	Annapolis, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
William Leece, Jr. Annapolis, Md.	2-25-59	Arthur S. Thomas			

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Hospital

Name of Doctor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02256

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 1306 Montgomery Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ellen	Middle S	Last Welling	4. DATE OF DEATH February 27	Month 1959	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1875		9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Name		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Channing M. Smith		14. MOTHER'S MAIDEN NAME Lucy D. Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Lucy A. Bass, Laurel, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Ventricular Fibrillation 1 day		INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic heart disease 10 yrs			
		Arteriosclerotic heart disease 10 yrs		Gastric Ulcer + Pancreatic Ulcer 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastric Ulcer + Pancreatic Ulcer						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20/1959 to 2/27/1959, that I last saw the deceased alive on 2/10/1959, and that death occurred on 2/25/1959, from the causes and on the date stated above. ACTUAL SIGNATURE J. M. WARREN PHYSICIAN'S NAME (Type) J. M. WARREN						ADDRESS (Street, city or town, state) Highland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Marks Cem.		22d. LOCATION (City, town, or county) Highland Md	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson		ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR MAR 3 '59		24b. REGISTRAR'S SIGNATURE Orville S. Turner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 can be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE CHARTER OF THE GOVERNMENT OF THE STATE OF WISCONSIN

1
FOR STATE
HEALTH DEPT.

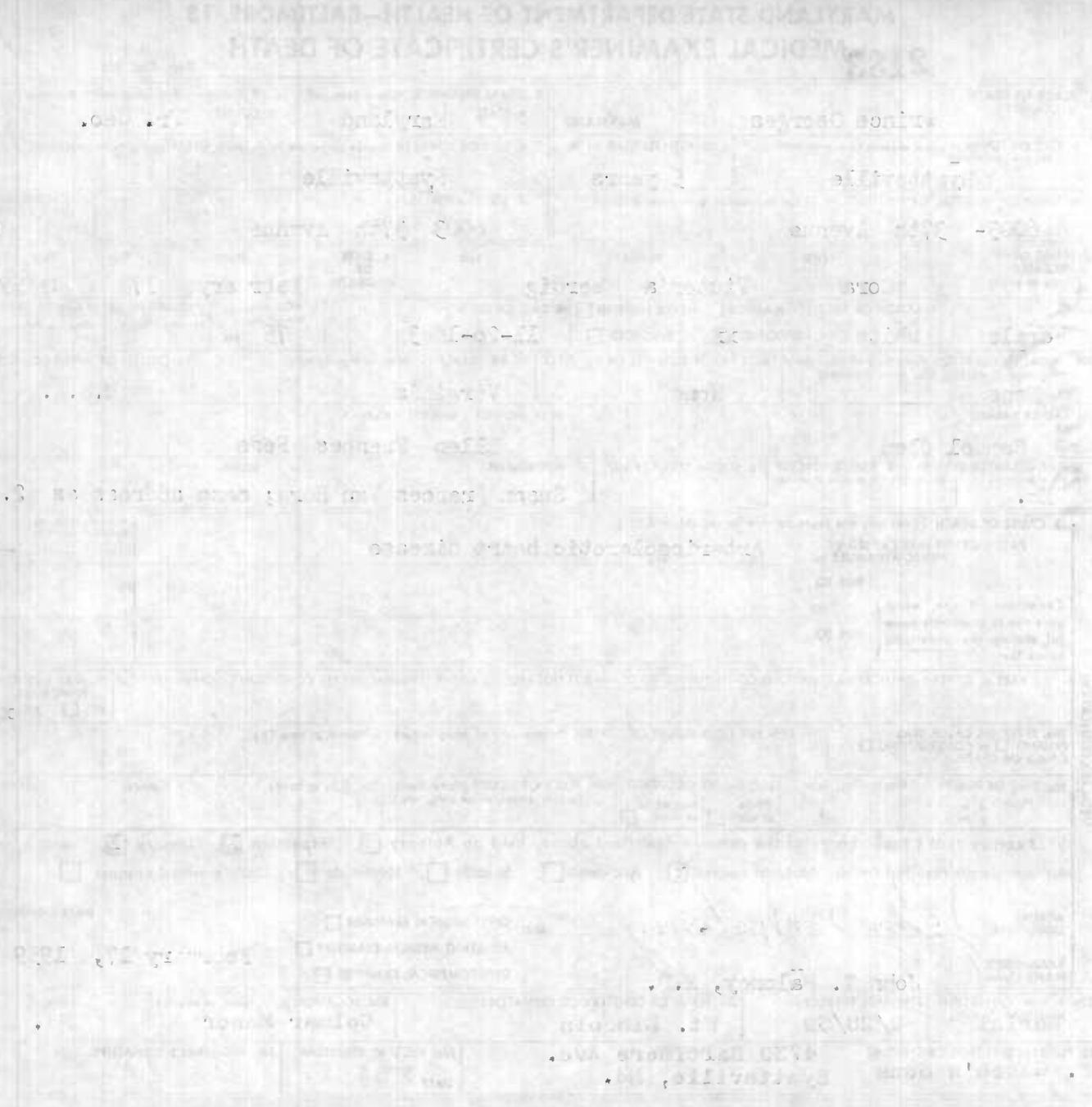
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust凭单. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02257

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6003- 37th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora		First Victoria	Middle Werdig
4. DATE OF DEATH February 17	Month 19	Day 59	Year
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1883
9. AGE (In years last birthday) 75 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Clem	
14. MOTHER'S MAIDEN NAME Ellen Frances Hess		15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No.	
16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT Address Susan Frances Van Horn; same address as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John J. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 17, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF— 2/20/59	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln	22d. LOCATION (City, town, or county) Colmar Manor (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	4739 Baltimore Ave. Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE FEB 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2242

CERTIFICATE OF DEATH

02258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 12 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21 D C				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 6520 Oxen Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary J		First	Middle	Lost	4. DATE OF DEATH Month Feb	Day 4	Year 19 59	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 21 July 1891	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 442X		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Hattie Pickrell Oxen Hill, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulse Cong + edema DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension arterioscl. cerebral. DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) February 3, 1959						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Hyattsville Md.		
21. I certify that I attended the deceased from February 3, 1959 , to February 3, 1959 , that I last saw the deceased alive on February 3, 1959 , and that death occurred at 1, 18A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md. DATE SIGNED 2/4/59								
ACTUAL SIGNATURE T. E. Benjamin		M.D.						
PHYSICIAN'S NAME (Type) Dr. T. Benjamin		Hyattsville Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/59		22c. NAME OF CEMETERY OR CREMATORIUM St Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		ADDRESS		24a. REG. BY REGISTRAR FEB 10 1959		24b. REGISTRAR'S SIGNATURE Arthur J.		
				DATE				

81 DEPARTMENT OF HEALTH-ENVIRONMENT

CERTIFICATE OF DISEASE

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG239 3-2-59 et

CERTIFICATE OF DEATH

02259

Reg. Dist. No.

2243

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY P.G.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN lb 4 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 LAUREL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 407 Montrose Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Margaret	Middle G	Last Wright	4. DATE OF DEATH Feb. Month 20 Day Year 19 59	
5. SEX Female	COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1881 Dec. 23 /18810/	9. AGE (In years last birthday) 78 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min. Address
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Isaac Fisher			14. MOTHER'S MAIDEN NAME Elizabeth — ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Bernhardt Wright	Address Forest Hill Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X DUE TO Cerebral infarction INTERVAL BETWEEN ONSET AND DEATH 1 w/e Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, generalized DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 16 19 59 to Feb. 20 19 59 , that I last saw the deceased alive on Feb. 20 19 59 , and that death occurred at 8:20A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) George J. Hagerage M.D. DATE SIGNED					
ACTUAL SIGNATURE George J. Hagerage M.D.					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2.23.59	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery	22d. LOCATION (City, town, or county) Baltimore County (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.			ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2274

CERTIFICATE OF DEATH

Reg. Dist. No.

n2260

1. PLACE OF DEATH a. COUNTY <i>Prince George Co</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>7902 Foster St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>ELLA</i>		First	Middle	Lost	DATE OF DEATH <i>ZIELENSKY</i>	Month <i>Feb</i>	Day <i>11</i>	Year <i>1959</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec 25 1886</i>	9. AGE (In years last birthday) yrs. <i>72</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Warsaw Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>							
13. FATHER'S NAME <i>Frank Drust</i>		14. MOTHER'S MAIDEN NAME <i>Ella Drust</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Daughter, Mrs Anna Gardner</i>		Address <i>7902 Foster St, District Heights</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i> DUE TO <i>Congestive heart failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pyelonephritis</i>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7200 Franklin Pkwy</i>		(County) <i>Baltimore</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <i>7200 Franklin Pkwy</i>		DATE SIGNED <i>March 28 1959</i>	
ACTUAL SIGNATURE <i>Kelvin L. Minchin, M.D.</i>													
PHYSICIAN'S NAME (Type) <i>KELVIN L. MINCHIN, M.D.</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-13-1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedars Hill</i>		22d. LOCATION (City, town, or county) <i>Switzerland, Md.</i>						(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Mattingly</i>		ADDRESS <i>131-11 38th St Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>FEB 13 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>							

CERTIFICATE OF DEATH

aggravated Insanity. I certify that
upon & after the death

✓ three days

per 11 Dec 1913

Ex 18812552

minimum term now

now all

for 5 years from the date of birth

and first visit

or 5 months and 20 days

or 8 months and 20 days for one

intervening period

A.L.E

✓ still does

epilepsy

now & does

not

per 11/5 22 10:30 AM

per 10/5

KELVIN L. MUNCHIN, M.D.